Solicitation Information

February 18, 2013

LOI#: 7461245

TITLE: Medicaid Integrated Care Initiative for the Rhody Health Option Program

Submission Deadline: March 27, 2013 @ 10:00 AM (EST)

Questions concerning this solicitation must be received by the Division of Purchases at David.Francis@purchasing.ri.gov no later than **March 12, 2013 @ 12:00 AM Midnight (EST).** Questions should be submitted in a *Microsoft Word attachment.* Please reference **LOI# 7461245** on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

SURETY REQUIRED: No

BOND REQUIRED: No

David J. Francis
Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Note to Applicants:
Offers received without the entire completed four-page RIVP Generated Bidder Certification Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION FORM

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Appendices

CHAPTER ONE: GENERAL STATE REQUIREMENTS AND INSTRUCTIONS

This chapter includes general State requirements and notifications for interested parties to follow in preparing proposal submissions to serve as a Managed Care Organization (MCO) for the Rhode Island Medicaid adult populations including those individuals who are receiving long-term care services (institutional and home/community-based care) and those individuals who are Medicare beneficiaries and are eligible for full Medicaid benefits.

This is a Letter of Interest (LOI) and not a Request for Proposal (RFP) or an Invitation to Bid (ITB). Responses to this LOI will be evaluated on the basis of the relative merits of the technical proposal and bidder's acceptance of the terms in a Model Contract and the capitation rates, appended to this LOI. There shall be no public opening and reading of responses received by the State of Rhode Island, other than the names of bidders who have submitted proposals.

The following indicates the conditions associated with the LOI.

1.1 Issuing Agency and Officer

The Rhode Island Department of Administration/Office of Purchases, on behalf of the Executive Office of Health and Human Services (EOHHS), is soliciting Technical Proposals from qualified bidders to provide medically or functionally necessary services to eligible Medicaid recipients through a managed care program under a capitation contract. EOHHS is the issuing agency for this LOI. The Administrator of Purchasing, as noted on the LOI Cover Sheet, shall serve as the sole point of contact for this LOI. This LOI and any subsequent award(s) are governed by the State's **General Conditions of Purchase** (available at www.purchasing.ri.gov).

1.2 General Instructions and Notifications to Bidders

The following provides general instructions and notifications to potential respondents to this LOI:

- Potential Bidders are advised to review the Rhode Island's General Conditions of Purchase for contractors available at www.purchasing.ri.gov.

- Potential Bidders are advised to review all sections of this LOI carefully and to follow the instructions completely, as failure to make complete submission as described elsewhere herein may result in rejection of the proposal.

- Alternative approaches and or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of the work defined in this LOI will be rejected as being non-responsive.

- All costs associated with developing and submitting a proposal in response to this LOI or to provide oral or written clarification of its content shall be borne by the Bidder. The State assumes no responsibility for any costs associated with preparing the proposals.

- Proposals are considered to be irrevocable for a period of not less than one hundred twenty (120) days following the opening date, and may not be withdrawn, without the express written permission of the State Purchasing Agent.

- Proposals misdirected to other State locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be considered. For the purpose of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.

- It is intended that an award pursuant to this LOI shall be made to two or more primary contractor(s), who will assume overall responsibility for the provision of Medicaid Managed Care Services. Joint ventures and cooperative proposals shall not be considered. Subcontracts are permitted, provided their use is clearly indicated in the vendor's proposal. And the subcontractor(s) to be used is identified in the proposal.

- Interested parties should be aware that all materials associated with this LOI are subject to the terms of the Freedom of Information Act, the Privacy Act, and all rules, regulations, and interpretations of these Acts, including those from the offices of the Attorney General of the United States, U.S. Department of Health and Human Services (HHS), and CMS.

- Interested parties are advised that all materials, except for proprietary information, submitted to the State for consideration in response to this LOI shall be considered to be Public Records as defined in Title 38, Chapter Two of the Rhode Island General Laws, without exception, and will be released for inspection immediately upon request.

- In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporations, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).

- The State reserves the right not to enter into a contract with any interested party of this procurement if the proposals do not respond to State's needs, at the time of review. The State also reserves the right to make use of all ideas contained in the submission, whether future procurements are issued or not, or whether future contracts are awarded or not.

- Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this LOI.

- Interested parties shall be aware of Rhode Island's Minority Business Enterprise (MBE) requirements and the State's goal of achieving ten percent participation by MBE's in all State procurements. For further information, contact the MBE Administrator at (401) 574-8253 or visit the web site at www.mbe.ri.org or contact cnewton@gw.doa.state.ri.us.

- Proposals shall contain a completed and signed four-page RIVIP Certification Form and a completed and signed W-9 Form (taxpayer identification number and certification). These forms may be downloaded at www.purchasing.ri.us.

- The purchase of services under an award pursuant to this LOI will be contingent on the availability of funds.

- Interested parties submitting a proposal shall register on-line at the State Purchasing website at www.purchasing.ri.us.

- American Recovery and Reinvestment Act of 2009 (ARRA) Supplemental Terms and Conditions. For contracts and sub-awards funded in whole or in part by the American Recovery and Reinvestment Act of 2009. Pub.L.No. 111-5 and any amendments thereto, such contracts and sub-awards shall be subject to the Supplemental Terms and Conditions for Contracts and Sub-awards Funded in Whole or in Part by the American Recovery and Reinvestment Act of 2009. Pub.L.No. 111-5 and any amendments thereto located on the Division of Purchases website at www.purchasing.ri.us.

- The State reserves the right to amend this LOI at any time with respect to the implementation of Federal Health Reform (Patient Protection and Affordable Care Act-PPACA).

1.3 Confidentiality and Protection of Public Health Information and Related Data

The successful Bidder is required to execute a Business Associate Agreement, Data Use Agreement, and any like agreement, that may be necessary from time to time, and when appropriate. The Business Associate Agreement, among other requirements, shall require the successful bidder to comply with 45 C.F.R. § 164.502(e), 164.504(e), 164.410, governing Protected Health Information ("PHI") and Business Associate under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et.seq., and regulations promulgated there under, and as amended from time to time, the Health Information Technology for Economic and Clinical Health Act (HITECH) and its implementing regulations there under, and as amended from time to time, the Rhode Island Confidentiality of Health Care Information Act, R.I. General Laws, Section 5-37.3 et.seq.

The successful Bidder shall be required to ensure, in-writing, that any agent including a subcontractor, to whom it provides Protected Health Information received from, or created or received by and/or through this contract, agrees to the same restrictions and conditions that

apply through the above described Agreements with respect to such information.

1.4 Code of Ethics and Professional Behavior

It is the policy of the State of Rhode Island that public officials and employees will adhere to the highest standard of ethical conduct; respect the public trust and rights of all persons; be open, accountable, and responsive; avoid the appearance of impropriety; and not use their positions for private gain or advantage.

No person subject to the code of ethics will have any interest, financial or otherwise, direct or indirect; engage in any business, employment, transaction, or professional activity; or incur any obligation of any nature which is in substantial conflict with the proper discharge of his/her duties or employment in the public interest and of his/her responsibilities, as prescribed in the laws of this State.

No person subject to the code of ethics will accept other employment, which will either impair his/her independence of judgment as to his/her official duties or employment or require him/her, or induce him/her, to disclose confidential information acquired by him/her in the course of, and by reason of, his/her official duties.

No person subject to the code of ethics will willfully and knowingly disclose, for pecuniary gain, to any other person, confidential information acquired by him/her in the course of, and by reason of, his/her official duties or employment or use any such information for the purpose of pecuniary gain.

No person subject to the code of ethics will use, in any way, his/her public office or confidential information received through his/her holding any public office to obtain financial gain, other than that provided by law, for himself/herself or spouse (if not estranged) or any dependent child or business associate, or any business by which said person is employed or which said person represents.

No person subject to this code of ethics, or spouse (if not estranged), or dependent child, or business associate of such person, or any business by which said person is employed or which such person represents, will solicit or accept any gift, loan, political contribution, reward, or promise of future employment based on any understanding that the vote, official action, or judgment of said person would be influenced thereby.

No person will give or offer to any person covered by this code of ethics, or to any candidate for public office, or to any spouse (if not estranged), or dependent child, or business associated of such person, or any business by which said person is employed or which such person represents, any gift, loan, political contribution, reward, or promise of future employment based on any understanding that the vote, official action, or judgment of said person would be influenced thereby.

In accordance with regulations pursuant to Title 37, Chapter Two, the State's Chief Purchasing Officer is authorized to investigate and resolve conflicts, including, but not limited to, the

following measures: (1) reassignment of the State employee involved, (2) termination of the State employee involved, (3) debarment of any/all vendors involved.

CHAPTER TWO: BACKGROUND

The Executive Offices of Health and Human Services (EOHHS), is the designated single state agency for Medicaid in the State. There are five State Departments and Divisions that expend Medicaid funds: The Executive Office of Health and Human Services (EOHHS); the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH); The Department of Children, Youth and Families (DCYF); the Department of Human Services Division of Elderly Affairs (DEA); and the Department of Health (DOH). EOHHS accounted for seventy-five percent of the expenditures and BHDDH accounted for twenty-two percent.

This chapter provides potential bidders background information about the Rhode Island Medicaid program and the reasons for this procurement.

2.1 Rhode Island Medicaid Program

The Medicaid Program is a principal source of health care coverage and services in Rhode Island. The Rhode Island Medical Assistance Program (Medicaid) has expanded over the years beyond the role of being a safety net to becoming a principal source of health care coverage and services, having served approximately one-third of the State's population within the last five years. It is now an integral part of the State's health care delivery system, serving over 224,000 Rhode Islanders in SFY 2011, at a cost of $1.824 billion dollars. Medicaid expenditures make up approximately 25 percent of the State's budget.

Between SFY 2006 and 2010, total Medicaid medical expenses based on the date of service has increased 2.5 percent per year. This increase is based on a 2.5 percent increase in per-member-per-month (PMPM) cost and a zero percent increase in enrollment, which considered together determines the average expenditure growth. These expenditure trends compare favorably to both national Medicaid expenditures and state commercial insurance cost trends.

The expenditures for each major population group for SFY 2011 are noted below:

- **Adults with disabilities:** account for the largest share of expenditures (38 percent and $702 million) at an average PMPM of $1,997 and represent 16 percent of the Medicaid population. The major source of expenditures for this population is residential and rehabilitation services for the developmentally disabled (28 percent) and hospital care (26 percent).

- **Elders:** represent nine percent of the Medicaid population and account for 26 percent of Medicaid expenditures ($475 million). Elders have the highest average PMPM cost of $2,257. Nursing facilities account for roughly two-thirds of the expenditures.

- **Children and families:** represent 68 percent of the total enrollment and account for 26 percent of the total expenditures ($462 million). Average PMPM for Children and families is $ 322.04.

- **Children with special health care needs (CSHCN):** is a relatively small population (seven percent of the recipients) and account for 10 percent of the expenditures ($179 million). The average PMPM for this population is $ 900.41.

Thus elders and adults with disabilities represent 22 percent of the Medicaid recipients and account for 64 percent of the expenditures. Seventy-seven percent of the Medicaid population is enrolled in a Health Plan and accounts for 48 percent of Medicaid expenditures. (In part this is because the vast majority of managed care enrollees are in the RIte Care program, which has a lower PMPM cost, than the elder or adult disabled populations**).**

Hospitals and nursing homes account for nearly 48 percent of all program expenditures. (Hospitals account for 29 percent and nursing homes account for 19 percent of the expenditures). Payments to hospitals increased by an average of 8.2 percent per year between 2007 and 2011. Payment to nursing homes increased by 1.8 percent between 2007 and 2011. Medicaid expenditures are highly concentrated. The top seven percent of Medicaid recipients account for over two-thirds of the expenditures. The average cost associated with these 16,188 recipients was $68,708 per person.

Over the past five years, Medicaid has seen a decline in low cost users and an increase in high cost users of Medicaid services. If this trend continues, it will have a significant impact on future Medicaid expenditures unless appropriate intervention strategies are implemented.

2.2 Evolution of Managed Care

When Medicaid began in the mid-1960s, the RI Medicaid program was modeled as a traditional indemnity fee-for-service (FFS) health insurance program. Throughout the years, the State has progressively transitioned from a payer to an active purchaser of care. Central to this has been a focus on improved access and quality along with cost management as core program objectives. Contracting with "accountable" entities provides a structure for measuring and enforcing performance standards. The state has been able to leverage the capabilities of Managed Care Organizations (Health Plans) and the Primary Care Case Management (PCCM) program (in such areas as network capacity, member services, care management and coordination) while maintaining a strong oversight role.

The State's initial Medicaid managed care program, RIte Care, began in 1994, enrolling over 70,000 low income children and families. A key contractual element was the "mainstreaming" provision, requiring that Health Plans must ensure that if a provider accepted enrollees from commercial lines of business, they must also accept RIte Care enrollees without discrimination. The number of providers participating in RIte Care Health Plans networks represented marked expansion over fee-for-service, with primary care provider participation more than doubling. Physician visits more than doubled by June 1998. In November 1998 RIte Care expanded to families with children under 18 including parents and relative caretakers with incomes up to 185 percent of FPL; and in 1999 expanded to children up to age 19 in households with incomes up to 250 percent of the FPL with the passage of federal legislation establishing the State Child

Health Insurance Program (SCHIP). Children in Substitute Care Arrangements**:** were voluntarily enrolled in RIte Care in December 2000 and Children with Special Health Care Needs (CSHCN) were voluntarily enrolled in RIte Care in 2003. Enrollment for CSHCN became mandatory in 2009.

The Program for All-inclusive Care for the Elderly (PACE) was implemented in December 2005. On average, 200 beneficiaries are enrolled in the State's fully integrated program for frail elders who are Medicare and Medicaid Eligible (MME) beneficiaries. To be eligible for PACE, participants must be age 55 or older, meet a nursing facility level of care, and live in the PACE organization service area. The PACE program features a comprehensive medical and social service delivery system in an adult day health center that is supplemented by in-home and referral services in accordance with participants' need. By coordinating and delivering a full spectrum of services, PACE helps enrolled beneficiaries remain independent and in their homes for as long as possible. PACE is operated and funded through a three way agreement between CMS/Medicare, Rhode Island Medicaid, and The PACE Organization of Rhode Island (PORI).

The Connect Care Choice (CCC) program was implemented in 2007 as the State's Primary Care Case Management model to serve the adult populations with complex medical and behavioral health conditions. The CCC program offers extensive care management services through 17 comprehensive medical home practice sites. Currently, there are 1701 individuals enrolled in the program.

In 2008, voluntary enrollment in Rhody Health Partners was implemented for persons with disabilities. In the fall of 2009, all Medicaid eligible "aged blind and disabled" (ABD) adults without third-party coverage who resided in the community were required to either enroll in a Health Plan through the Rhody Health Partners program, or in the State's FFS Primary Care Case Management (PCCM) program, Connect Care Choice (CCC). Currently there are 13,577 enrolled in the Rhody Health Partners Program.

This progression of expanded enrollment in managed care is characterized by enrollment of populations with increasingly complex health needs. Over this period, the contractual requirements of Health Plans have also expanded in terms of program requirements and in covered benefits, as the state has increased the performance requirements of Health Plans for managing the health care needs of complex populations. Health Plans were not required, however, to pay for home and community-based services but did pay for 30 days of nursing home stays.

Appendix A is a Data Book that provides additional information on the Medicaid populations affected by this procurement.

Currently, there are two Health Plans participating in the RI managed care programs: (1) Neighborhood Health Plan of Rhode Island (NHPRI), and (2) UnitedHealthcare Community Plan (United). The total enrollment in both of these Health Plans for the RIte Care and Rhody Health Partners (RHP) program was 139,379 on September 30, 2012. Table 1 below indicates managed care enrollment for the Medicaid recipients by Health Plan.

Table 1: Managed Care Program Enrollment (as of September 30, 2012)

PROGRAM	NHPRI	UNITED	TOTAL
RIte Care	85,858	40,233	126,091
Rhody Health Partners	6,287	7,001	13,288
TOTAL	92,145	47,234	139,379

The total managed care capitation expenditures for SYF 2011 were $646.9 million. The expenditures for each managed care population group are indicated in Table 2 below.

Table 2: Managed Care Program Expenditures (SFY 2011)

PROGRAM	EXPENDITURES
RIte Care	$447.2 Million
Rhody Health Partners	$199.7 Million
TOTAL	$646.9 Million

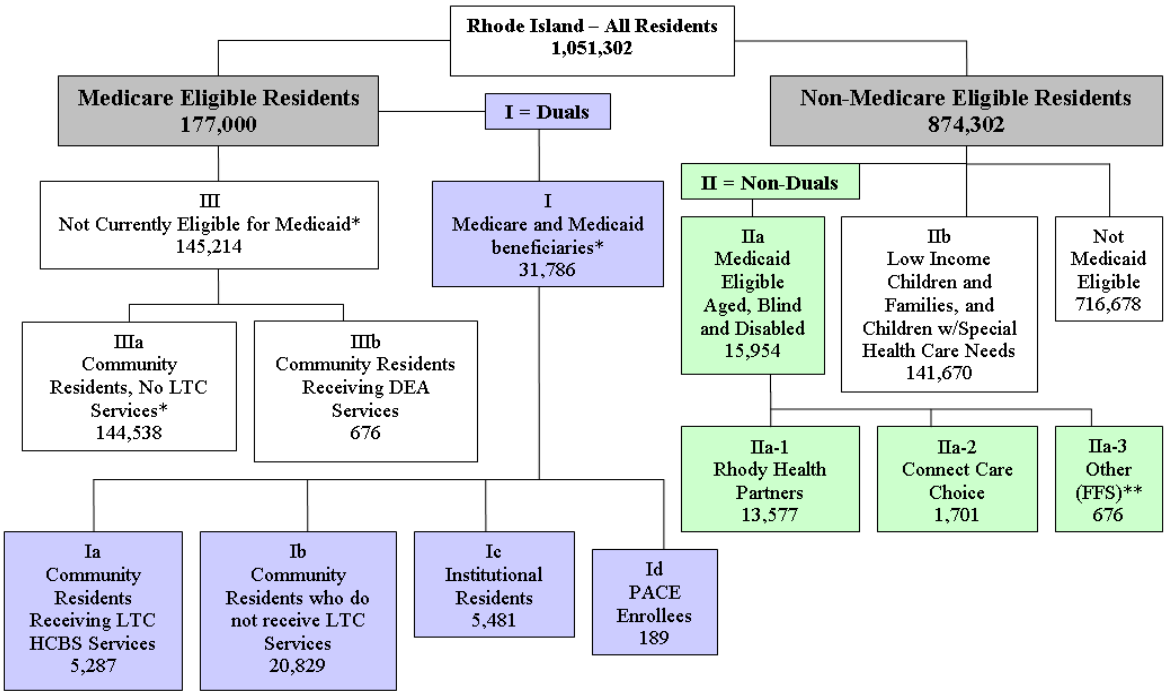
Currently there are seventeen Connect Care Choice practice sites statewide. In SFY 2011, the Connect Care Choice program enrollment totaled 2,015 members. The total SFY 2011 expenditures for the Connect Care Choice program were $43,790,391 million.[1]

2.3 Medicare Medicaid Eligible Population

Table 3 below provides an additional perspective on the Medicare and Medicaid populations in the State as well as the populations receiving long-term services and supports (LTSS).

Table 3: The Rhode Island Medicaid Population (SFY 2011)

[1] ACEMedicaidExpense 20120808.xls



* Note that in SFY 2011 there were 3,527 Qualified Medicare Beneficiaries (QMB), Specified Low-Income Beneficiaries (SLMB) and Qualified Individuals (QI) beneficiaries not eligible for full Medicaid benefits for whom Medicaid pays only a Medicare premium plus the patient share (for QMBs) of Medicare services. These individuals are included in III and IIIa, above. In addition, there were 4,031 Medicare and Medicaid Eligibles (MMEs) who were enrolled in Medicare Advantage plans in SFY 2011.

** Includes members who are either in institutions or have non-Medicare third party coverage.

Sources: 2010 US Census, Kaiser State Health Facts, 2011 data. Medicaid data are based on SFY 2011 figures.

Note that the Medicaid figures presented in Table 3 are averages per day during SFY 2011.

Over the course of twelve months the number of unique individuals in any of these categories is larger.

Over seventeen (17) percent of Rhode Islanders are Medicare beneficiaries (i.e. 177,000 Medicare beneficiaries out of a total population of 1,051,302). That is not surprising since fourteen (14) percent of the State's population is 65 years old or over. Rhode Island has the fifteenth (15th) largest proportion of elder residents in the nation. The current elder population is

expected to increase by twenty-one (21) percent from the current 154,541 to 247,000 individuals by 2030.

Over seventeen (17) percent or 31,786 (i.e. average eligible) of Medicare beneficiaries are also eligible for the Medicaid program. The group is commonly referred to as "Dual-Eligible" or "Medicare and Medicaid Eligible (MME)". The number of residents who are eligible (i.e. average eligible) for Medicaid is 189,410 (i.e. Boxes I, IIa and IIb).

The MME population presents many challenges. Individuals in this group often have more complex medical conditions, greater functional impairments, are more socially isolated, are less educated, suffer from cognitive impairments and are more costly to serve. As previously indicated there are 27,622 MME individuals in Rhode Island who are eligible for full Medicaid benefits. The total Medicare and Medicaid cost of serving these individuals is $931.4 million ($292.8 million for Medicare funding and $ 638.6 million of Medicaid funding).

In SFY 2011, the MME members represented 16 percent of the total Medicaid population and accounted for Medicaid expenditures of $638.6 million. Medicaid-only adults with disabilities represented 9 percent of the population with expenditures totaling $309 million. Combined, these two groups account for 25 percent of beneficiaries and at $1.087 billion, approximately 59 percent of total Medicaid expenditures. Currently, 21 percent of the dual population is in an institutional long-term care setting which accounts for 74 percent of total expenditures for the dual population. Approximately, 14 percent of the MME population is enrolled in a Medicare Advantage Plan (MAP).

Residential and long-term care expenditures for institutional and waiver services constitute over 94 percent of the Medicaid cost for MME members. By contrast, 63 percent of the expenditures for the Medicaid-only members lie in acute care services. For this group, the costs for hospital services represent 62 percent of the total acute care cost. The hospital setting of care is the most utilized and leading cost of care for the Medicaid-only beneficiaries.

Medicare benefits emphasize medical interventions that are expected to restore the health status or functioning of the individuals. Consequently, most Medicare costs are contained in acute expenditures. For the majority of Medicare members, the coverage is adequate. However, as health status becomes more complex or deteriorates, Medicare's coverage frequently becomes too limited. Medicare does not cover custodial services provided in long-term care settings or home and community-based services. The lack of coverage for the latter set of services for adults with developmental disabilities, many of whom will require such care on a continuous basis, typically brings Medicaid eligibility early on as an adult, usually as part of the transition from youth-based programs. By contrast, for elders and other adults with disabilities, it is an adverse health event that creates the need for the non-Medicare covered services. At such points, Medicaid becomes the payer for the wide array of critical services and supports needed across both institutional and community-based settings. The Data Book found in Attachment A provides additional information on the population covered under this procurement.

The Medicare and Medicaid programs were not designed to work together. Both programs operate separately and distinctly, leading to a fragmented financing system for providers who

serve people on both programs, and uncoordinated care for the consumer. By design, Medicare funds primary, specialty, and acute care while Medicaid funds predominately long-term services and supports, including nursing home admissions. The impact of the fragmentation becomes most evident at critical moments when a MME beneficiary is transitioning from one care setting to another. For example, when a MME client is discharged from a hospital to home, the discharge planning conducted at the hospital (Medicare funded) is often not well coordinated with the care plan for supports in the home (Medicaid funded) upon discharge. Few incentives, resources, or mechanisms for care coordination exist in the current FFS system.

There are three critical issues related to the current system that need to be addressed to improve the services to the dual population and to control costs:

- **Improve Coordination of Care.** Without the proper coordination and discharge planning, MME individuals are vulnerable to emergency department visits, readmissions to the hospital and nursing home stays that are potentially avoidable or longer than necessary. MME individuals do not currently benefit from a coordinated and integrated care team. This can result in unmet needs or improper utilization of the health care system. The integration of Medicare and Medicaid funding streams will lead to more seamless care delivery and improve the quality of care, and access to care for beneficiaries covered by both programs.

- **Align Financial and Quality Incentives.** A longstanding barrier to coordinating care for MME individuals has been the financial misalignment between Medicare and Medicaid and the conflicting requirements for payers, providers, and beneficiaries. The financial incentives are not currently aligned to promote coordination between the two programs. This fragmentation has led to inefficiencies in the way care is paid for, the way providers render care, and the way beneficiaries access their care.

- **Improve System Navigation.** The Medicare and Medicaid programs not only cover different benefits, but also have different administrative procedures and rules in place. These dichotomies leave MME individuals to navigate a bifurcated system of benefits and rules with limited assistance and no single place for members and their caregivers to direct questions regarding their benefits, their provider networks, etc. Providers are often thrust into the role of care coordinator, spending an inordinate amount of time determining which program to seek prior approval from to deliver services, which program to submit claims to, and which program to appeal to, if a provider does not agree with a benefit decision. Among other advantages, an integrated system would allow members and providers to have a single source of information on benefits, billing, grievances and appeals, and general information.

These factors have created the impetus for Rhode Island to develop new approaches for improving the access, coordination and quality of care in a more cost-effective manner.

2.4 Long-Term Care

What is critical to the State is the number of individuals who receive or who are at-risk of

requiring long-term services and supports (LTSS) and become potential future Medicaid recipients. For example, as indicated in Table 3, 676 Medicare beneficiaries receive LTSS through the Division of Elderly Affairs (DEA) because their current income or assets are above Medicaid standards (as indicated in Box IIIb). While 15,960 full benefit MME individuals presently reside in the community without home and community-based services (Box Ib), approximately 2,551 of them are persons with severe and persistent mental illness (SPMI). Also it is estimated that within this group of community-based MME individuals upward of ten percent are at increased risk for needing home and community based supports within two years, based on historical utilization patterns. As indicated in Table 3, 5,286 MMEs are presently receiving Home and Community Based Services (HCBS) to help maintain their ability to continue living in the community (Box Ia). It is estimated that 2,324 are individuals with functional limitations and developmental disabilities. Additionally, there are 5,481 duals living in an institutional setting on an average day (Box Ic). It is estimated that a total of 9,000 recipients are in an institutional setting on any given day. It is further estimated that seventy-five percent of those recipients are institutional residents for nine or more months. There are 189 individuals enrolled in the PACE program. Of the 15,000 Medicare only aged, blind and disabled adults, it is estimated that at least one-third will become MME within two years of obtaining Medicaid eligibility.

In State Fiscal Year (SFY) 2011, Medicaid long-term care expenditures for services provided by EOHHS were $ 423.5 million. Institutional care expenditures were $279.5 million or 86 percent and HCBS were $82.8 million or 14 percent. RI has a significantly higher rate of utilization of nursing homes than the national average, with 56 nursing home residents per 1,000 individuals, as compared to 38 nursing home residents per 1,000 individuals nationally. RI ranked fourth in the nation in the proportion of overall population that spent ninety days or more in a nursing home. In addition, RI nursing home residents are less impaired and have a lower severity of need than the national average. The high use of nursing homes, longer stays and the lower acuity levels of need provides RI with a significant opportunity to provide long-term services in a community-based setting, which is less costly and often more desirable to consumers.

Access to and the availability of long-term care services and supports is a critical issue in Rhode Island. Long-term care services are particularly critical for the frail elderly, children and youth who are involved in the child protective and criminal justice systems, and adults with disabilities, including developmental disabilities. All too often, these individuals are served in an institutional rather than in a community-based setting. RI has been committed to and is working on improving the availability of options for those requiring long-term care for a number of years now. Some of the most salient initiatives include:

- The creation of a Governor's Cabinet on Chronic and Long Term Care. In 2004, the Acting Director of the Center for Gerontology and Health Research at Brown University conducted a special study entitled *A Vision for the Present and Future: Rethinking Chronic and Long Term Care in RI.*

- In 2006, the RI Department of Human Services, pursuant to a joint resolution of the RI General Assembly commissioned the University of Maryland, Baltimore County, to

conduct a study about existing efforts and recommendations to improve the delivery of community-based LTSS in the State.

- The Long-Term Care Service and Finance Reform Act (Perry/Sullivan) legislation included: provisions for nursing home savings reinvested in home and community-based services, uniform long term care provider cost reports, improved information and referral, streamlined identification and assessments, and increases for specific home and community-based providers.

- In 2006, RI was awarded the Real Choice System Transformation Grant to improve Information and Referral, Long-Term Care Services and Supports, Quality Management, and Finance and Payment reforms.

- In January 2009, the Global Consumer Choice 1115 Demonstration Waiver was approved by CMS. The overriding purpose of the Waiver is to provide the State with the flexibility to get the right services, to the right people, at the right time and in the right setting. The Waiver is built upon three fundamental goals: (1) to rebalance the State's long-term care system, (2) to integrate care management across all Medicaid populations, and (3) to complete the transition from a payer to a purchaser of care. It establishes a new State-Federal compact that provides the State with substantially greater flexibility than was available in previous guidelines. Rhode Island uses the additional flexibility to redesign the Medicaid program to provide more cost-effective services and care in the least restrictive and most appropriate setting. Today, the State operates its entire Medicaid program under the Global Consumer Compact Choice Waiver demonstration. The compact waiver establishes an aggregate budget ceiling for Federal reimbursement, with the exception of disproportionate share hospital payments, administrative expenses, phased Medicare Part D contributions and payments to local education agencies.

- The Medical Assistance Reform Act passed by the General Assembly in June 2009, provided the Legislative authority to implement the Global Waiver and provided for a cross-section of stakeholders to be convened on a monthly basis to provide input on the implementation of the provisions of the Global Waiver changes.

- Affordable Care Act (ACA) of 2010 provides additional opportunities to rebalance the Long-Term Care delivery system in RI and to implement systems that provide for a continuum of coordinated care for individuals with complex medical conditions.

- The State has established a Long-Term Care Coordinating Council that meets regularly and has the Healthy RI Task Force that bring together stakeholders to improve the long-term care delivery system in the State and to identify opportunities created under the ACA, respectively.

Over the past several years, the State has convened on-going workgroups with stakeholders who have worked diligently to develop consensus recommendations for reform. The following describes our LTSS system and efforts to rebalance LTSS resources.

RI has recently made a number of systems reform improvements to rebalance the delivery of long term care services from the institutional setting to a home and community based setting. RI has developed and implemented a standardized long-term care assessment tool and created level of care criteria for long-term care services. In addition, RI has implemented a Nursing Home Transition Program to help an individual transition from a nursing facility to the community. A State staffed Assessment Team (composed of a registered nurse and a licensed clinical social worker) in collaboration with all nursing homes statewide: (1) identify potential Medicaid beneficiaries that may be transitioned to a home or community based setting, (2) conduct an assessment to determine whether the beneficiary is appropriate for a home/community setting, (3) provide information about options so beneficiaries and their families can make an informed decision, (4) ensure that needed supports and services are in place prior to the nursing home discharge, and (5) work with the beneficiaries with medically complex conditions throughout the transition period. During SFY 2013 the State has transitioned 30 individuals back into the community, and on average 100 people per year transition from a nursing home to the community.

To complement the rebalancing long term care initiatives, RI has implemented a multi payer Advanced Primary Care Practice demonstration, the Chronic Care Sustainability Initiative (CSI) and patient centered medical home initiatives. These efforts to strengthen primary care and the medical home concept provide a strong medical safety net for individuals as they transition into the community.

In April 2011, Rhode Island also received a Money Follows the Person (MFP) demonstration grant from the Centers for Medicare and Medicaid Services (CMS) to transition eligible RI residents that are in an institutional setting for 90 days or more to "MFP qualified" community-based settings. The MFP program in Rhode Island is entitled *Rhode to Home (RTH).* The RTH program introduced the use of Transition Coordinators who provide the intensive case management services required by elders and adults with physical disabilities during the demonstration period when the participant's needs are greatest to ensure that participants have access to a comprehensive array of home and community based services (HCBS) and supports so that they successfully remain in the community. RTH will also provide Peer Mentoring sservices which is a necessary component of case management and supports for people with disabilities. Peer Mentor services will be designed to be provided during the transition period and thereafter, if necessary. Peer Mentors are individuals with disabilities who are successfully living in the community. We believe the initiatives underway will continue to position RI to achieve the goal of 50/50 balance of long-term care resources between institutional and home and community based care.

In June 2011, legislation was passed to change the payment methodology for Nursing Facilities. The proposal seeks to eliminate the cost basis principles of reimbursement and replace it with a base payment structure that reimburses Nursing Facilities appropriately based on the needs of

the Medicaid beneficiary. Additional acuity payment adjustments would be factored into the payment methodology.

Today, the State Medicaid program offers a comprehensive array of institutional and community-based LTSS. These services and supports are found in Attachment A of the appended Model Contract. Currently, Health Plans are only required to provide up to thirty (30) days of nursing home care for RHP members and those members requiring more days are disenrolled from the Health Plan. LTSS services are currently provided as an out-of-plan benefit for members enrolled in a Health Plan or in CCC.

The long-term care providers in the State include: 93 nursing homes (84 accept Medicaid recipients), approximately 56 home nursing care providers, 14 home care providers, 19 adult day care centers, and 51 assisted living facilities operating in different locations throughout the State. A list of the State's long-term care providers is contained in Appendix B[2].

Rhode Island licenses Home Nursing Care Providers and Home Care Providers. Home Nursing Care Providers provide skilled nursing services and can also provide more general home care services i.e. assistance with daily living and care, housekeeping, companion shopping). Home Care Providers do not provide "skilled" services, but can provide assistance with daily living and personal care. Businesses that provide homemaker and companion assistance only, that is, they do not provide personal care or direct hands-on assistance with daily life care, do not require a license. Network providers are subject to the rules and regulations of the Department of Health. Home Nursing Care Providers can also be certified to meet Federal Medicare services authorized under the Federal CFR Title 18 regulations and are "certified for Medicare."

2.5 Integrated Care Initiative

EOHHS and stakeholders recognized that there is an opportunity to improve the Medicaid program by enhancing the integration of all services required by ABD Medicaid recipients including primary care, acute care, specialty care, behavioral health care and long-term services and supports and to include those individuals who are Medicare and Medicaid eligible in those integration efforts. These populations have complex medical conditions, require a multi-disciplinary cadre of care and supports, and are costly to serve. It is not surprising therefore that the Integrated Care Initiative (ICI) focuses on these populations.

In 2010, the ACA recognized the needs of these population groups and promoted the coordination of services for adults with disabilities (ages 19 to 64) and for elders (age 65 and older). In July 2011, the RI General Assembly also recognized the importance of improving the systems serving these populations:

By joint resolution pursuant to Rhode Island General Laws relating to the Medicaid Reform Act; Section 3 of Article 16: Integration of Care and Financing for Medicare and Medicaid

[2] Source data for this information derived from the RI Dept. of Health Licensing database, January 2013

Beneficiaries, the Executive Office of Health and Human Services is directed to engage in a contractual arrangement for the expansion and integration of care management strategies by July of 2012 for Medicaid-only beneficiaries and MME members.

As a result, the ICI was established.

The vision of the State is to have an Integrated Health Care System for all Medicaid-only and MME members that will achieve improved health and well-being, better healthcare, at lower costs. EOHHS's mission is to transform the delivery system through purchasing person-centered, comprehensive, coordinated, quality health care and support services that promote and enhance the ability of Medicaid-only and MME recipients to maintain a high quality of life and live independently in the community.

A key requisite to meet the State's vision and mission for the ICI is to build on, improve, and integrate the current Care Management programs to better meet the needs of the target populations. The goals of ICI are the following:

- Enhance person-centered care
- Improve and maintain member's quality of life and care
- Develop an integrated system of care and coordination of services
- Increase the proportion of individuals successfully residing in a community setting
- Reduce long term care costs by providing person-centered care in the most appropriate and cost-effective setting
- Decrease avoidable hospitalizations, emergency room utilization and reduce nursing home admissions and length of stay

EOHHS's ICI is founded on a care philosophy to ensure that services are delivered in the most appropriate care setting for each member based on their medical, behavioral health and social service needs. This philosophy incorporates CMS' tenets of Managed LTSS:

- **Person-driven:** The system affords older people, people with disabilities and/or chronic illness the opportunity to decide where and with whom they live, to have control over the services they receive and who provides the services, to work and earn money, and to include friends and supports to help them participate in community life.

- **Inclusive:** The system encourages and supports people to live where they want to live with access to a full array of quality services and supports in the community.

- **Effective and Accountable:** The system offers high quality services that improve quality of life. Accountability and responsibility is shared between public and private partners and includes personal accountability and planning for long term care needs, including greater use and awareness of private sources of funding.

- **Sustainable and Efficient:** The system achieves economy and efficiency by coordinating and managing a package of services that are appropriate for the beneficiary and paid for by the appropriate party.

- **Coordinated and Transparent:** The system coordinates services from various funding streams to provide a coordinated, seamless package of supports, and makes effective use of health information technology to provide transparent information to consumers, providers and payers.

- **Culturally Competent:** The system provides accessible information and services that take into account people's cultural and linguistic needs

In order to achieve the goal of full integration (primary care, acute care, specialty care, behavioral health care and long term services and supports), the State proposes to follow two primary pathways. This approach will allow for consumer choice and will ensure accountability, access and improved outcomes for MME members and those members requiring long-term care services and supports. Each of the models is not exclusive of the other and the State will pursue both major pathways in parallel. A summary of the primary pathways is below.

- **<u>Pathway #1: Enhanced Primary Care Case Management (PCCM) Models</u>**

  The Enhanced PCCM Model, Connect Care Choice *Community Partners (CCCCP)*, builds on the Connect Care Choice (CCC) Program's demonstrated capacity and experience to serve individuals with complex medical conditions. Currently, 17 CCC practice sites, meeting standards of performance adopted from the chronic care model of "best practices" serve approximately 1,800 Medicaid-only beneficiaries across Rhode Island. The CCC model encompasses primary care/nurse case management teams and co-located behavioral health to provide quality focused and holistic care to beneficiaries. CCC is designed to achieve and preserve access to primary, preventive, behavioral health and specialty care that allows the individual to remain well and independent in the community and decrease unnecessary acute episodes of care.

  Under the *CCCCP* model, the strengths of CCC are combined with an enhanced capacity in care management and service integration across all service categories: primary care, acute care, specialty care, behavioral health and long-term care services and supports. This pathway preserves the core person-centered medical home aspect of the CCC and builds on the established chronic care model of best practices. For members needing LTSS, the LTSS care management and transition services would be performed by the state staff within the EOHHS Office of Community Programs (OCP). To address the needs for greater integration of primary care, acute care, specialty care, behavioral health and long-term care services and for high touch care coordination, a bundled service contract will be sought to build **Coordinating Care Entity (CCE)** which would oversee and manage the performance data, quality assurance and quality improvement activities and build a **Community Health Team (CHT)** that would coordinate the social supports and services for the Medicaid-only and MME members

The CCE would coordinate the high touch care management with the existing CCC Nurse Care Managers integrated in the CCC Primary Care Practice sites and the EOHHS Office of Community Programs (OCP) Nurse Care Managers for the LTSS and CHT to provide linkages to social supports for a coordinated, seamless delivery system.

This CCE will be a community based entity with demonstrated expertise and the necessary tools to perform the coordination of the care management, care coordination, transition services, community based resource services, social supports, housing, transportation supports, and services integration functions in collaboration with the CCC practices. For Medicaid-only members, the *CCCCP* will be a direct expansion of the existing CCC program to include an increased focus on long-term care services and linkages to social supports. For MME individuals, the CCE will take responsibility for coordinating care and service integration, through the CCC, OCP and CHT. This program will be operated under the direction of the Administrator of the Office of Long Term Services and Supports RI Medicaid Program.

RI Medicaid will seek to define the advanced model of primary care established by the CCC*CP* program and the contracted CCE/CHT as a "health home," as defined by the Section 2703 under the Patient Protection Affordable Care Act. Under the "health home" program, the CCE, in concert with the CCC practice, OCP and CHT will be required to focus on prevention, reduce wasteful fragmentation, and avert the need for unnecessary and costly emergency department visits, hospitalizations and institutionalizations. We anticipate that an estimated three thousand five hundred (3,500) MME individuals as well as the existing 1,800 Medicaid only eligible ABD adults will choose this model.

The LTSS services that are currently funded and managed through the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH) will continue to be funded and managed through BHDD. The Bidder shall be required to coordinate these services with the BHDDH social caseworker and the BHDDH support coordinator.

- **Pathway #2: Health Plan Model**

The State will contract with two or more Health Plans to provide the comprehensive array of primary care, acute care, specialty care, behavioral health, and long-term care services and supports to Medicaid-only adults who receive LTSS as well as to MME individuals who are eligible for full Medicaid benefits, under a capitation arrangement. The target populations for this procurement fall into four groups: (1) MMEs living in the community receiving no long-term care services or supports, (2) MMEs living in the community receiving long term care services and supports, (3) MMEs living in an institutional care setting, and (4) Medicaid-only adults who receive LTSS in a nursing home or in the community.

This model will be implemented in two phases.

The Medicaid ICI as set forth in this LOI represents **Phase I** of EOHHS's approach to

improving the Medicaid program by enhancing the integration of the full range of services (primary care, acute care, specialty care, behavioral health care and long-term services and supports) for all Medicaid eligible adults, importantly including persons who are dually eligible for Medicaid and Medicare. Additionally, as described below, certain services for individuals with developmental disabilities and individuals with severe and persistent mental illness will not be included in Phase I.

Phase II includes the provision of all Medicaid covered benefits to the Medicaid only adults who receive LTSS and to all full benefit MMEs population, except for those individuals who are specifically excluded from this initiative as described in the Model contract appended to this LOI. Phase II includes the provision of all Medicaid benefits and Medicare benefits to the Medicaid only and to dually eligible Medicaid and Medicare individuals.

As is set forth in this LOI, the Phase I initiative is scheduled to commence enrollment on September 1, 2013.

EOHHS intends that Phase II – slated to commence twelve months following the start of Phase I - will incorporate three additional critical components to the ICI. The successful Bidder must successfully meet the requirements of these components. These three components are:

Rhody Health Partners

Presently, just over 13,000 Medicaid-only ("non-duals") beneficiaries are enrolled in the Rhody Health Partners program for all of their acute care services. LTSS waiver services are out-of-plan and continue to be Medicaid FFS. In Phase I, Rhody Health Partners program includes those individuals who are eligible for Medicaid only services, exclusive of LTSS. When an individual has been a resident in a long term care setting for more than thirty (30) consecutive days, that individual is currently disenrolled from Rhody Health Partners. Both of these events contribute to discontinuity of coverage for the enrollee. Individuals receiving LTSS and persons with greater than 30 days of consecutive residence in a long term care setting will be enrolled in Rhody Health Options in Phase I for the full scope of Medicaid services.

It is intended that at the start of Phase II, all of the Rhody Health Partners population will transition to be newly included in the enrollment for the Integrated Care Initiative. Participating Health Plans will be required to demonstrate their capability to meet all program requirements for this population. For additional background on this population the Procurement Library established in support of this LOI includes the Data Book for rate determination for SFY 2013.

Services for Persons with Developmental Disabilities and Persons with Severe and Persistent Mental Illness (SPMI)

During Phase I all MME individuals in these groups will be enrolled in a Health Plan.

However, during this period services that are currently funded and managed through BHDDH will continue to be funded and managed through BHDDH. Attachment B of the Model Contract identifies those services that will remain "out-of-plan" during Phase I.

During Phase II, EOHHS intends that those specialized services funded and managed by BHDDH for individuals with SPMI and developmental disabilities may become in-plan services as designed by new State requirements.

Each of these two population groups has a unique set of special needs and determining how best to serve these adults requires additional review and specification by BHDDH and EOHHS. EOHHS is committed to reviewing the experiences and best practices of other states in this area in partnership with BHDDH to ensure that the needs of adults with developmental disabilities and with SPMI will be well served within the ICI.

In consideration of transitioning those specialized services, in whole or in part, into a managed model in Phase II, EOHHS and BHDDH will establish program performance requirements and capabilities that will serve as the basis for managing these programs. This work will take place in the months following the release of this LOI, to be completed by July 2013. The relationship between the Health Plans in Phase I and the design of specialized services for Phase II into an integrated system will be specified in the July 2013 requirements.

Medicare and Medicaid Financial Alignment

Pursuant to provisions of the ACA, CMS has established the Financial Alignment Initiative seeking to better align the financing of the Medicare and Medicaid programs and integrate primary, acute, behavioral health and long term services and supports for MMEs. Rhode Island is pursuing a three year CMS demonstration for a capitated model utilizing a three way contract between CMS, the state and qualified Health Plans covering all Medicare and Medicaid services.

To participate in this initiative Rhode Island, along with twenty-five (25) other states, submitted a proposal for participation in this demonstration. Rhode Island's proposal is currently undergoing CMS review. As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, CMS and participating States want to ensure that every selected Medicare/Medicaid plan (MMP) is ready to accept enrollments, protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers, and fully meet the diverse needs of the MME population. As such, every selected MMP must pass a comprehensive joint CMS/State readiness review.

To participate in Phase II, in addition to all other requirements specified in this LOI, Health Plans must meet all Medicare requirements established by CMS for the capitated financial alignment model, including Medicare Part D requirements. See Section 3.2 for additional information. Every selected MMP must also pass a comprehensive joint

CMS/State readiness review.

Phase I of Rhode Island's Integrated Care Initiative will occur prior to the target capitated Financial Alignment Demonstration start date, and is set forth as the initial step and foundation for participation in the Demonstration. MME individuals who are eligible for full Medicaid benefits will receive them in Phase I under the Rhody Health Options program. Phase II is intended to include the full integration of Medicare and Medicaid services through a three way contract. EOHHS is working with CMS to ensure that dually eligible beneficiaries in Rhode Island are able to benefit from this program. It is essential that successful vendors responding to this LOI are able to provide evidence of their ability to qualify as a participating plan in this Demonstration.

The timing of this Phase II component may vary from those above and will be determined in concert with CMS.

Consumers may still elect to enroll in the PACE program administered by PORI who meet the eligibility requirements, pending the availability of the program's capacity to serve new members.

2.6 Enrollment Approach

The consumer will have a choice with regard to which model they will enroll in: the *CCCCP* Model, the Health Plan model, or the PACE model. However, the capacity to enroll new members is particularly limited with PACE, and somewhat limited with the *CCCCP* model. Member will also have a choice with the selection of the Health Plan that they will enroll in. This section highlights the number of individuals who are eligible for the ICI and the State's overall approach to enrollment.

The total eligible population that will participate in Phase I of the Integrated Care Initiative is approximately 28,578 individuals (900 current Rhody Health Partners members, 273 current CCC members, and 27,405 MME recipients). Once the program is fully operational, it is estimated that there will not be a net increase in monthly enrollments (i.e. new eligible members will be equal to the number of members who disenroll or become deceased in any given month, based on current eligibility criteria and population trends. It is further estimated that the total ICI population enrolled in the *CCCCP* model will be approximately 5,000 individuals and the remaining 23,578 will be enrolled in an Health Plan. PACE enrollment is estimated to remain the same.

When the ICI commences, the current recipients of Medicaid will be enrolled over a four month period for both the CCC and Health Plan models.

- **Month One:** individuals who were previously enrolled in RIte Care, CCC or RHP and were dis-enrolled because Their status changed to MME (approximately 1,000 individuals)

- **Month Two:** MME and Medicaid-only individuals who reside in a nursing home and

one-third of the MME population not receiving LTSS (approximately 10,000 individuals).

- **Month Three:** MME and Medicaid-only individuals who receive LTSS at home and one-third of the MME population not receiving LTSS (approximately 8,000 individuals).

- **Month Four**: the remaining one-third MME not receiving LTSS, and MME members with SPMI and MRDD clients (approximately 10,000 individuals).

Medicaid-only members currently enrolled in a Rhody Health Partners Health Plan and a participating CCC site will be sent a letter indicating that they may keep their current Health Plan (if that Health Plan is selected to participate in the Integrated Care Initiative) or CCC site, but will also be offered the option to change to the other Model. For members not enrolled in a Health Plan or assigned to a specific CCC site, they will be sent a letter indicating that they have been auto-assigned to one of the Health Plans. The auto-assignment to a Health Plan will be equal and random, but will take into account the following:

- If historical utilization data is available for primary care, and a member's primary care provider (PCP) is participating in one of the participating Health Plans' networks, auto-assignment will be made to that Health Plan.

- If an eligible member resides in a household with a RIte Care or Rhody Health Partners member(s), that member will be assigned to the same Health Plan as the RIte Care/RHP member, if that Health Plan is selected for the Integrated Care Initiative.

- If an eligible member was previously enrolled in RIte Care or Rhody Health Partners or CCC, and was disenrolled because of dual status or nursing home residence, auto-assignment will be to the last known CCC Site or Health Plan the member was enrolled in, if that Health Plan is participating in the ICI.

All members will be given the opportunity to change their auto-assigned Health Plan or to enroll in the CCC program if they choose to, within a six-week period.

To enroll new members, the State will make a "sweep" of all new eligible recipients, monthly. They will also be auto-assigned to a Health Plan based on the criteria cited above and a letter which will be sent to them two months prior to their enrollment date. These members will have a six-week period to change their auto-assignment. However, a member can choose to change between the Health Plan and the *CCCCP* model on a monthly basis (and vice versa). Members cannot however opt-out to fee-for-service (FFS) Medicaid.

A consolidated Member Services call center team will be created to answer incoming calls and to implement or make changes in the Health Plan and PCCM assignments and to provide information about the PACE option.

The remainder of this LOI only pertains to the requirement related to the Health Plan Model.

CHAPTER THREE: PROGRAM AND TECHNICAL REQUIREMENTS

The successful Bidder must demonstrate the capacity to provide high quality services in a cost-effective manner to eligible Medicaid populations throughout the State of Rhode Island. The selected Health Plan must have the capability to meet a defined set of program and technical standards related to; their licensure and accreditation status, and ability to: enroll the covered population and provide a comprehensive array of medical, behavioral health, and long-term care services and support that represent a continuum of care; maintain a robust multi-disciplinary provider network that meets Federal and State accessibility standards; demonstrate capacity to provide care management to a diverse population with complex needs; coordinate both in-plan and out-of-plan services to meet individual member needs; demonstrate capacity to provide responsive member and provider services; provide effective medical management and meet quality standards; demonstrate the financial capacity to operate under a risk bearing contract and to meet fiscal standards; maintain a viable Information Technology capacity to serve as a Health Plan and report information to the State; and maintain a grievance and appeals process to meet Federal and State requirements. The successful Bidder will also be required to meet specific terms and conditions related to: contract amendments and potential contract disputes; personnel and performance standards; confidentiality of information; and other terms and conditions related to administering its contract with EOHHS.

The following are the guiding principles and care philosophies that Bidders are expected to embrace when serving Rhody Health Options members under this procurement.

- Establish and maintain a person-centered system of care.
- Facilitate access to timely, appropriate, accessible and quality primary care, acute care, specialty care, behavioral health care, long-term services and supports.
- Include in the network Patient Centered Medical Homes designated by NCQA for primary care and Home-Based Primary Care. All NCQA recognized practices should be included in the Health Plans network.
- Provide members with the full continuum of Medicaid covered services through a multi-disciplinary network of providers.
- Promote an integrated and coordinated system of care that meets member needs.
- Ensure that the primary care settings serve as an effective medical home.
- Conduct a comprehensive needs assessment to assess the member's medical status, functional status, behavioral health, risk factors and social service needs.
- Develop an integrated Plan of Care tailored to member's medical, behavioral health, LTSS, social services, and special needs.

- Provide services delivered in the most appropriate care setting for each member based on their medical, functional, behavioral health, and social service needs.

- Increase the proportion of individuals successfully residing in a community setting.

- Decrease avoidable hospitalizations, emergency room utilization and reduce nursing home admissions and lengths of stay.

- Build on and link with existing community resources to meet member needs.

- Tailor "successful evidenced-based practices" from other environments to meet the needs of Rhode Islanders.

- Maximize the use of technology that improves access and the provision of care while reducing costs and integrating or coordinating with the state.

- Empower members to self-direct their care, when appropriate.

- Build on existing Medicaid long-term care rebalancing initiatives including the Money Follows the Person grant to leverage existing resources and to improve quality and health care outcomes in community based settings.

The following highlights the key programmatic and technical requirements that successful Bidders are expected to meet for this procurement.

3.1 Model Contract Requirements

A key component of the LOI is the model contract. The model contract sets forth the terms of agreement with EOHHS for an award pursuant to this LOI.

Appendix C contains the model contract for the forthcoming procurement period. The Model Contract is organized as follows.

Article I: Definitions

Article II: Health Plan Program Standards

1. General
2. Licensure, Accreditation, Certification
3. Health Plan Administration
4. Eligibility & Program Enrollment
5. Member Enrollment and Disenrollment
6. In-Plan Services
7. Coordination of Out-of-Plan Services
8. Provider Networks

9. Service Accessibility Standards
10. Member Services
11. Provider Services
12. Medical Management & Quality Assurance
13. Operational Data Reporting
14. Grievance & Appeals
15. Payment To and From Plans
16. Health Plan Fiscal Standards
17. Record Retention
18. Compliance

Article III: Contract Term & Conditions

1. General Provisions
2. Interpretations & Disputes
3. Contract Amendments
4. Payment
5. Guarantees, Warranties, & Certifications
6. Personnel
7. Performance Standards & Damages
8. Inspection of Work Performed
9. Confidentiality of Information
10. Termination of Contract
11. Other Contract Term & Conditions

Addendum I:	Fiscal Assurances
Addendum II:	Responsibilities under Title VI of the Civil Rights Act of 1964
Addendum III:	Responsibilities under Section 504 of the Rehabilitation Act of 1973
Addendum IV:	Drug Free Workplace Policy
Addendum V:	Drug Free Workplace Policy Provider Certificate of Compliance
Addendum VI:	Subcontractor Compliance
Addendum VII:	Certification Regarding Environmental Tobacco Smoke
Addendum VIII:	Instructions for Certification Primary Covered Transactions
Addendum IX:	Certification Regarding Primary Covered Transactions
Addendum X:	Certification Regarding Lobbying
Addendum XI:	American Recovery and Reinvestment Act of 2009 Terms and Conditions
Addendum XII:	Business Associate Agreement

Attachment A:	Schedule of In-Plan Benefits
Attachment B:	Schedule of Out-of-Plan Benefits
Attachment C:	Schedule of Non-Covered Services
Attachment D:	Nutrition Standards for Adults
Attachment E:	Federally Qualified Health Centers (FQHC) & Rural Health Center (RHC) Services
Attachment F:	Contractor's Locations

Attachment G:	Contractor's Capitation Rates
Attachment H:	Contractor's Insurance Certifications
Attachment I:	Rate Setting
Attachment J:	Performance Goals
Attachment K:	Special Terms & Conditions
Attachment M:	Care Management Protocols
Attachment N:	Nursing Home Transition Including *Rhode to Home* Requirements
Attachment O:	Quality and Operations Reporting Requirements
Attachment P:	Medicare Readiness Checklist and CMS Requirements

Bidders are urged to read the model contract carefully and thoroughly. The model contract describes the binding requirements between the State and the Contractor. Bidders will be bound to the requirements and capitation rates contained in this Model Contract. Contractors are expected to have policies, procedures and practices that demonstrate compliance with the requirements contained in this Model Contract.

The following highlights the major elements and key requisites for being a successful Bidder and a compliant Contractor.

3.2 Health Plan Organization

The Bidder must meet all State general requirements as described in Chapter One.

To serve as a Health Plan Contractor, the Bidder must be licensed as a Health Maintenance Organization (HMO) or as a Health Plan (HP) in the State of Rhode Island by the Rhode Island Department of Health and the Rhode Island Department of Business Regulation prior to signing an Agreement with the State.

The Bidder must also be accredited by the National Committee for Quality Assurance ("NCQA") as a Medicaid managed care organization or otherwise for a newly entering plan. In the latter case, (1) the Contractor must submit a PDF copy of its current NCQA accreditation certificate for a Medicaid managed care organization in another State, (2) the Contractor must submit a specific time line outlining the Contractor's plan to achieve full accreditation within twelve months of the execution of the contract, and (3) failure to obtain accreditation by the date specified will result in the suspension of enrollment. Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the Final Report from the NCQA and may result in termination of the State's Agreement with the Contractor. In the event that NCQA were to deny accreditation to the Contractor, the State shall consider this to be cause for termination of the Agreement.

The Bidder agrees to forward to EOHHS any complaints received from the Rhode Island Department of Business Regulation, the Rhode Island DOH, or NCQA concerning its licensure, certification, and/or accreditation within thirty (30) days of Contractor's receipt of a complaint.

The Bidder must be in good standing with the Medicare and Medicaid programs and NCQA. The licensure, accreditation and certification requirements are more fully discussed in the Model Contract in Section 2.02.

The Bidder must demonstrate compliance with the Affordability Standards issued by the RI Office of Health Insurance Commissioner (OHIC). The Affordability Standards aim to improve the affordability of health care in the State by requiring companies issuing health insurance to: (1) expand and improve primary care infrastructure, (2) adopt patient centered medical homes, (3) support CurrentCare, the State's information exchange, and (4) work toward comprehensive payment reform across the delivery system. The Procurement Library contains additional information about the State Affordability standards.

The success of the Rhode Island Medicaid managed care program is contingent on the financial stability of participating Health Plans. The Bidder must be financially solvent, have the capital, and have the financial resources and management capability to operate under this procurement's risk-based contract that reimburses the Health Plan with capitation rates.

The Bidder is required to have the staffing capacity with the appropriate expertise, the administrative procedures, organization structure and management information system to perform all the functions required under this contract (e.g. program and service development, member enrollment, member services, claims processing, accounting and finance, quality assurance, medical management, and utilization review, provider network development and continuing relations, care management etc.).

The Bidder is required to have an office in the Providence area of Rhode Island. The Bidder may perform some administrative functions out-of-state, with the approval of EOHHS, as long as it does not affect the quality, effectiveness, and efficiency of the services or functions performed by the Bidder in the judgment of EOHHS.

CMS Requirements for Phase II Participation

As noted, the Bidder will not be able to participate in Phase II unless it has met all Medicare requirements established by CMS for the capitated financial alignment model, including Medicare Part D requirements.[3]

Medicare requirements include but are not limited to areas including: submission of a Notice of Intent to Apply (NOIA) for Capitated Financial Alignment Demonstration Contracts no later than January 31, 2013 (prospective demonstration plans were advised to submit NOIAs by November 14, 2012); Part D benefit, including formulary and Medication Therapy Management Program (MTMP) submission and approval; solvency/licensure; fiscal soundness; administrative and management arrangements; network adequacy for Medicare medical services and prescription drugs; evidence-based Model of Care (MOC); submission of an integrated plan benefit package; and provision and coordination/integration of benefits. CMS shall determine whether all such requirements have been met. Medicare past performance is a criterion to accept passive enrollment. Among the mechanisms CMS will use to assess an organization's Medicare

[3] For additional information, see: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html

performance are the sanctions, the Past Performance Review methodology, and the Medicare Plan Finder "consistently low performing" icon (LPI). Not only will CMS not allow plans to accept passive enrollments based on Medicare past performance/LPI but RI will also use plans' past performance/LPI status as criteria in the selection process.

In order to participate in the financial alignment model (Phase II), MCOs must also submit applications to CMS via the Health Plan Management System (HPMS) by February 21, 2013, the same application timeline as Medicare Advantage and Part D. A number of Medicare requirements noted in the previous paragraph will be included in the application. As part of the application, MCOs must submit a Model of Care specific to the demonstration, as well as preliminary network information, and information on solvency/licensure, fiscal soundness, and administrative and management arrangements. MCOs must also submit Medication Therapy Management Programs by a May 2013 submission deadline; Part D formularies by May 31, 2013; plan benefit packages by June 3, 2013; and Additional Demonstration Drug (ADD) files and Part D supplemental formulary files by June 7, 2013.

In addition, every selected MMP must also pass a comprehensive joint CMS/State readiness review.

Please see CMS guidance released on January 9, 2013 for additional detail on the requirements and timeframes for the Medicare portion of the joint CMS and State plan selection requirements for the capitated financial alignment demonstrations.

To the extent that any content in a Rhode Island Memorandum of Understanding (MOU) or a three-way contract for the financial alignment model conflicts with the requirements in this LOI, the MOU and/or three-way contract content shall supersede the LOI content.

3.3 Implementation Schedule and Contract Period

The Bidder is expected to be ready to assume responsibility for the Phase I Contract between the Contractor and EOHHS on September 1, 2013. The Phase I Contract will continue in force until June 30, 2016, with three (3) one year option periods.

It is anticipated at this time that the tri-party Phase II demonstration contract with CMS, EOHHS and the Contractor that includes the provision of Medicare services will be for three (3) years commencing twelve months after the start of Phase I.

3.4 Member Enrollment and Disenrollment

Marketing

The Bidder may conduct marketing campaigns for members, subject to the restrictions noted in the *Marketing and Approval of Written Materials, Protocols for Medicaid Managed Care*

Programs, issued by the State. Bidders may not display or distribute marketing materials, nor solicit members in any other manner, within fifty feet of Rhody Health Options eligibility and enrollment offices, unless it has received permission to do so from the State.

For Phase I, the Bidder submits all marketing materials to the EOHHS for approval prior to use. All marketing materials are written at no higher than a sixth-grade level, in a format and a manner that is easily understood. EOHHS determines whether Health Plan marketing plans, procedures, and materials are accurate, and do not mislead, confuse, or defraud either recipients or the State, pursuant to 42 CFR 438.104. When engaged in marketing targeted to Rhody Health Options members, the Bidder: (1) does not distribute marketing materials to less than the entire service area, (2) does not distribute marketing materials without the approval of the EOHHS, (3) does not seek to influence enrollment in Rhody Health Options in conjunction with the sale or offering of private insurance, and (4) does not, directly or indirectly, engage in unsolicited door-to-door, telephone, or other cold call marketing activities.

Enrollment

The Bidder has State approved written policies, procedures, systems and practices that meet the requirements prescribed in Section 2.05 of the Model Contract. The State supplies the Health Plan on a monthly basis with a list of Health Plan enrollees.

The Bidder enrolls a member no more than seven (7) calendar days after receiving notification from the State. Members are mailed notification of Health Plan enrollment including effective date and how to access care within ten (10) calendar days after receiving notification from the State of their enrollment. The Bidder agrees to report any changes in the status of individual member within five (5) days of their becoming known, including but not limited to changes in address or telephone number, out-of-State residence, deaths, household composition (e.g. birth of a child or change in legal guardianship of a minor) and sources of third-party liability.

The Bidder provides orientation to new members about their benefits, the role of the PCP, what to do in an emergency or urgent medical situation, how to utilize services in other circumstances, how to register a complaint or file a grievance and how to implement advance directives in accordance with Federal and State legal requirements (See Model Contract for specific legal citation). Instructional materials relating to members are written at no higher than a sixth-grade level, presented in a manner and format that may be easily understood. All written materials are available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who are visually limited or have limited reading proficiency. All members are informed that information is available in alternative formats and how to access those formats.

The Bidder makes at least four attempts, on different days, to make a welcome call to all new members within thirty (30) days of enrollment to provide the same information as in the paragraph above. Welcome call scripts also solicit whether members have new or existing health care needs, including pregnancy or any chronic disease, such as asthma, diabetes, or a behavioral health need. In the event that a welcome call identifies any new members who have existing health care needs immediate steps will be taken (e.g. referral to the Contractor's Care

Management Department) to ensure the member's needs are met. Any scripts developed or used by the Health Plan are subject to review by EOHHS.

The Bidder makes at least four attempts, not counting two on the same day**,** to contact the member within ten (10) days of notification of enrollment to provide information on options for selecting a PCP. The Bidder offers freedom of choice within the PCP network of participating providers to members in making a selection. Leaving a voicemail message does not constitute an offering of freedom of choice of a PCP. If a member does not select a PCP during enrollment, the Bidder makes an automatic assignment, taking into consideration such factors as current provider relationships, language needs (to the extent they are known), member's area of residence and the relative proximity of the PCP to the member's area of residence. Whenever feasible, auto-assignment of a PCP will be to an NCQA-recognized PCMH. The Bidder notifies the member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired.

Materials

The Bidder issues all Rhody Health Options members an identification card within ten (10) days after receiving notification from the State of their enrollment. The card includes at least the following information: (1) Health Plan name, (2) twenty-four hour Health Plan telephone number for use in urgent or emergent medical situations, (3) telephone number for Member Services function (if different), and (4) PCP, or PCP practice, name and office telephone number (can be affixed by sticker to card).

The Bidder mails a Member Handbook to all members within ten (10) days of being notified of their enrollment. The Bidder publishes a revised Member Handbook within six (6) months of the effective contract date, and to update the handbook thereafter when there are material changes needed as determined by EOHHS. The Bidder includes all the information in the Member Handbook that is required in the Model Contract.

The Bidder submits all member materials to EOHHS for approval prior to its use. This includes any changes made to language previously approved by the State. Contractor also agrees to make modifications in member materials if required by the State.

Disenrollment

The State has sole authority for disenrolling members from Health Plans, subject to the conditions described in the Model Contract. The Bidder may not disenroll a member. The Bidder refers requests for disenrollment to EOHHS for determination.

3.5 Services and Accessibility Standards

The Bidder is required to provide the full range of primary care, acute care, specialty care, behavioral health care, and long-term services and supports (institutional care and HCBS and supports) as described in Section 2.06 and to meet the service accessibility standards contained in Section 2.09 of the Model Contract. In Phase I, only Medicaid benefits are covered in this procurement for MME beneficiaries (Medicare benefits continue to be covered by the member's individual Medicare Advantage Plan or by the Medicare fee-for-service system).

These services represent a continuum of care to meet the diverse and often complex needs of Rhody Health Options members. The covered services are listed below.

TRADITIONAL BENEFITS	HOME AND COMMUNITY BASED SERVICES
Inpatient Hospital Care	Adult Day Health Center
Outpatient Hospital Care	Assisted Living
Physician Services	Homemaker
Family Planning Services	Environmental Modifications
Prescription Drugs	Special Medical Equipment (Minor Assistive Devices)
Non-Prescription Drugs	Home Delivered Meals
Laboratory Services	Personal Emergency Reponses System (PERS)
Radiology Services	Community Transition Services
Diagnostic Services	Residential Support
Mental Health & Substance Abuse-Outpatient	Day Support
Mental Health & Substance Abuse-Inpatient	Supported Employment
Home Health Services	RIte@ Home
Home Care Services	Private Duty Nursing
Emergency Room Services & Transport	Support for Consumer Direction
Nursing Home Care & Skilled Nursing Facilities	Participant Directed Goods & Services
Other Practitioner Services (e.g. PA, CSW, Mid-wife)	Case Management
Podiatry	Senior Companion
Optometry	Personal Care Assistance Services
Emergency Oral health	Respite
Hospice	Cost Effective Alternative Services
Durable Medical Equipment	Screening, Brief Intervention & Referral to Treatment (SBIRT)
Nutrition Services	
Group Education	
Interpreter Services	
Transplants	

The Bidder is required to provide 365 days of nursing home care as medically and/or functionally necessary for the member inclusive of skilled care, custodial care or any other level of nursing home care including but not limited to emergency placement, hospice and respite care. Bidders will also be required to offer an array of Disease Management Programs, and Self-Help Medical Management Programs. The services and programs are fully described in Attachment A of the Model Contract. Certain services for individuals with Developmental Disabilities and individuals with SPMI will continue to be funded and managed by the BHDDH in Phase I. During Phase II, EOHHS in conjunction with BHDDS intends that those specialized

services funded and managed by BHDDS for individuals with SPMI and developmental disabilities may become in-plan services as designed by new State requirements. These out-of-plan services in Phase I are delineated in Attachment B of the Model Contract. The Bidder is required, however, to coordinate these services with BHDDH providers to ensure a holistic and integrated approach is employed to serve member needs.

The Bidder is also required to provide coverage, either directly or through its PCPs, to members on a twenty-four (24) hours per day, seven (7) days per week basis. If PCPs are to provide such coverage, Bidders must ensure that there is a back-up plan for instances where the PCP is not available. For Medicaid-only members, during Phase I, the Bidder agrees to make available to every member a PCP, whose office is located within twenty (20) minutes or less driving distance from a member's home. Members may, at their discretion, select PCPs located farther from their homes. Pursuant to 42 CFR 438.114, the Bidder agrees to provide or ensure access to Emergency Services which are available twenty-four (24) hours a day and seven (7) days a week, either in Contractor's own facilities or through arrangement, with other providers.

The Bidder agrees to develop a comprehensive provider network that can make services available within twenty-four (24) hours for treatment of an Urgent Medical Condition including a mental health or substance abuse condition. Bidder agrees to make services available within thirty (30) days for treatment of a non-emergent, non-urgent medical problem. This thirty (30) day standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) days. Bidder agrees to make services available within five (5) business days for diagnosis or treatment of a non-emergent, non-urgent mental health or substance abuse condition.

The Bidder allows women direct access to a women's health care specialist within the Bidder's network or outside the network for women's routine and preventive services. The Bidder must meet the Assessment Standards described in Section 3.9 of this LOI and as described in the Model Contract (Section 2.09. 07 and in Attachment M).

The Bidder must demonstrate that sufficient capacity exists to provide timely access to quality institutional care and HCBS and supports. Bidder is required to provide coverage, either directly or through contracted home care agencies to members with LTSS needs twenty four (24) hours per day, seven (7) days per week. The coverage must include the necessary LTSS for members residing in the community and who have an immediate need for a service that was scheduled and did not occur. These immediate needs include, but are not limited to failure of a personal care attendant (PCA) to arrive at the scheduled time, failure of home delivered meals to arrive at scheduled times, or failure of an assistive device to be delivered at a scheduled time. The Bidder is required to provide a consultation/assessment for LTSS within fifteen (15) calendar days of a member's or caregiver's request. Other specific assessment standards are described in Section 3.9 Care Management of this LOI. The required services for members must be in place within five (5) days of a member's determined need. Nursing homes must be located within ten (10) miles of a member's primary caregiver, unless a nursing home is selected by the member that is more than ten (10) miles. Assisted Living residences, Adult Day Service Centers and other community-based LTSS agencies must be located within twenty (20) minutes driving time of

the primary caregiver's residence, unless a member selects a provider that is more than twenty (20) minutes driving time of a member's residence.

The Bidder is required to provide all necessary HCBS, as defined above and in the Model Contract. In addition, the Bidder is required to honor all existing EOHHS approved service authorizations for the period of time authorized by EOHHS, and with the provider that received the authorization. EOHHS will provide all necessary information to the Bidder to comply with this requirement. The Bidder is allowed to use cost effective alternative services, whether listed as a covered or non-covered service or omitted in Attachment A of the Model Contract, when the use of such alternative services is medically appropriate and is cost effective. This may include, for example, use of nursing facilities as a step down alternative to acute care hospitalization or hotel accommodations for persons on outpatient radiation therapy to avoid the rigors of daily transportation.

The Bidder must assure that members receive an in-person visit to their residence within twenty-four (24) hours of being discharged from a hospital or nursing facility.

3.6 Provider Network

The Bidder is required to ensure that network providers meet the Provider Network requirements in Section 2.08 of the Model Contract.

The Bidder maintains a robust multi-disciplinary provider network: (1) to provide members with the full range of covered services inclusive of primary care, acute care, specialty care, behavioral health care and LTSS for the anticipated members in the service area, (2) that maintains providers in sufficient number, mix and geographic area, and (3) makes available all services in a timely manner.

In establishing and maintaining the network, the bidder considers the following:

- Anticipated Rhody Health Options enrollment
- Expected utilization of services taking into consideration the characteristics and health care needs of specific Rhody Health Options populations for which Contractor is, or will be, responsible
- Numbers and types (in terms of training, experience, and specialization) of providers, specifically specialty providers, required to furnish the services contracted for herein
- Numbers of providers who are not accepting new Rhody Health Options patients
- Geographic location of providers and members, considering distance, travel time, the means of transportation ordinarily used by members, and whether the location provides physical access for members with disabilities
- "Disability Competency" of providers and the physical accessibility of their offices; "Disability Competency" is defined as the capacity of health professionals and

health educators to support the health and wellness of people with disabilities through their disability knowledge and expertise

The provider network consists of a continuum of care required to meet the diverse and often complex needs of Rhody Health Options members and will contain, but not be limited to, the following:

- Primary Care Providers including Federally Qualified Health Centers, NCQA-recognized medical homes, and home-based primary care providers
- Specialty Providers
- Behavioral Health Providers
- Hospitals
- Therapy Providers (Physical, Occupational, Speech)
- Durable Medical Equipment Providers
- Labs and Radiology
- Institutional Long-Term Care Providers (Licensed nursing homes, nursing facilities and assisted living residences)
- HCBS Providers (home care agencies, home health agencies, adult day care health centers, RIte @ Home providers, care management providers, fiscal agents for self-directed care, etc.).

Network home care providers will not be required to be Medicare certified for Phase I, but must be overseen by a Medicare certified home care provider.

At the time a client transitions into managed care, the Bidder is required to maintain the member's current network of providers, including but not limited to, nursing home providers, assisted living providers, and home care providers for a period of six (6) months, after the member's start date. Members, who are permanent residents of nursing homes or assisted living facility in which they reside at the time they are enrolled, may remain in that nursing home or assisted living facility, regardless of whether that nursing home or assisted living facility is in-network for the Bidder.

The Bidder develops and maintains its network to maximize the availability of primary and specialty care access to reduce utilization of emergency services, preventable hospital admission/re-admissions, and the use of avoidable costly medical procedures. The Bidder includes in its network certain current FFS providers as "essential community providers", unless the Bidder demonstrates a valid reason for not including them. These "essential community providers" are listed in Appendix B. The Bidder is required to maintain the EOHHS contract terms with these "essential community providers", at EOHHS reimbursement rates, for a period of one (1) year. The Bidder agrees to notify the State monthly of any changes in its network's composition.

The inclusion of the following Mid-Level Practitioners - Certified Nurse Practitioners, and/or Physician Assistants - is permitted and encouraged. The State recognizes the ability of Mid-Level Practitioners to provide primary care to members.

Each Medicaid-only Health Plan member will have a PCP to serve as the member's medical home. The PCPs may be a primary care physician, a gynecologist, an internist, a gerontologist or other providers approved by EOHHS. The Bidder is expected to include NCQA recognized PCMHs in its network that serve as primary care providers. PCMHs provide and coordinate the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes. A list of PCMHs is provided in Appendix B. If the Bidders' primary care network includes Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs), it may designate either type of site as a PCP. In both instances, The Bidder must organize its PCP sites so as to ensure continuity of care to members and identifies a "lead physician" within the site for each member and the physician who is accountable as the PCP. The Bidder assigns no more than fifteen hundred (1,500) members to any single PCP in its network. For PCP teams and PCP sites, the Bidder assigns no more than one thousand (1,000) members per single primary care provider within the team or site, e.g., a PCP team with three (3) providers may be assigned up to three thousand (3,000) members.

The State considers mainstreaming of members into the broader health delivery system to be an important program objective. The Bidder agrees that all of its network providers accept members for treatment. Contractor agrees to have policies and procedures in place such that any provider in its network who refuses to accept a member for treatment cannot accept non-members for treatment and remain in the network.

The Bidder has written agreements with providers in their network. The Bidder is also required to comply with the requirements specified in 42 C.F.R. 438.214 which includes the selection and retention of providers, credentialing and re-credentialing requirements and non-discrimination. The Bidder has written protocols approved by EOHHS in the following areas:

- Credentialing, re-credentialing, certification and performance appraisal processes that all providers maintain knowledge, ability, and expertise in the service or specialty in which they practice.

- Nationally recognized practice guidelines and protocols that foster the quality of care and improve clinical outcomes (in accordance with 42 C.F.R. 438.236).

- Training and continuing education programs to ensure providers are knowledgeable about their specialty or subspecialty areas.

- Provider profiling to assess a provider's performance regarding the under/over utilization of services, clinical performance, interdisciplinary team participation, member access to care, member satisfaction, and other critical areas.

- A corrective action plan for a provider whose performance is unacceptable.
- Adequate reimbursement to maintain an adequate network that is based on value-based provider procurement contracting and performance-based reimbursement.

These elements are key requisites for an effective quality assurance program and are also

discussed in Section 3.12 of this LOI.

The network of providers must adhere to the following guiding principles of this Contract regarding the provision of care:

- Services are to be provided in accordance with State and Federal laws, regulations and requirements.

- Services are to be provided that promote the tenets of a person-centered care system.
- Services are provided promptly and are accessible in terms of the location and hours of operation as well as open access scheduling.

- Strong specialty care capabilities exist to address issues of cognitive impairment, frailty, disability, co-morbidity, late-stage life management issues and other special medical needs such as dementia.

- Policies and procedures that empower members, family and caregivers with enhanced self-management abilities.

- Services and care delivery focus on the prevention of illness and disabilities as well as the treatment of disease.

- Services are tailored to meet specific member needs and provided in a coordinated and integrated manner through a multi-disciplinary team approach.

- Policies and procedures exist to ensure that the rights and responsibilities of members are respected.

- Intervention strategies are implemented to identify and rectify unnecessary use of the emergency room, preventable hospital admission or avoidable institutionalizations.

- Innovative evidenced-based best practices are implemented to enhance the quality and cost-effectiveness of care (including the use of technology to support service delivery such as: the use of electronic medical records, e-mailing, and employing mobile medical technology.

- Alternative services are utilized to the minimize the reliance on limited medical resources to meet members' social service and support needs (such as the use of paramedical staff, medical concierge services, Transition Coordinator, Peer Navigators and a member informal support system) shall be implemented.

The Bidder has policies and procedures approved by EOHHS to: (1) monitor providers to assure that they meet Federal, State and contract requirements, (2) evaluate the quality of care delivered by providers (3) provide and arrange for medically and functionally necessary covered services, and (4) monitor the adequacy, accessibility and availability of its provider network to

meet the needs of its members, including the provision of care to members with special needs and with limited proficiencies in English.

A robust network of providers is critical to ensure that services result in optimal health outcomes, promote a member's independence and quality of life, and maximize the use of limited medical resources.

3.7 Person-Centered System of Care

The Bidder must implement a person-centered system of care that governs the care provided to Rhody Health Options members. The focus of a person-centered system of care is on the individual, their strengths, and their network of family and community supports in developing a flexible and cost effective plan to allow the individual maximum choice and control over the supports they need to live in the community.

A person-centered system of care respects and responds to an individual's needs goals and values. Within a person-centered system of care, individuals and providers work in full partnership to guarantee that each person's values, experiences, and knowledge drive the creation of an individual plan of care as well as the delivery of services. A person-centered system of care is built on the principle that members' have rights and responsibilities, know their circumstances and needs first-hand, and should be invested in the care they receive. Person-centered care establishes a foundation for independence, self-reliance, self-management, and successful intervention outcomes.

For members requiring LTSS, the Care Manager's role in the person-centered process is to enable and assist LTSS members to identify and access covered services and available LTSS providers. The member's personally defined outcomes, preferred methods for achieving them; training supports, therapies, treatments, and other services needed to achieve those outcomes become part of a written person-centered services and support plan. The person-centered Plan of Care also supports individuals' ability to self-direct services.
A person-centered system of care is strengths-based. Interventions are crafted based on the unique set of strengths, resources, and motivations that each member brings while recognizing and addressing needs, deficits and supports. The member, and/or his/her designee, is meaningfully involved in all phases of the care management process including in the Comprehensive Functional Needs Assessment of needs, development of an integrated Plan of Care, delivery of care and support services, and in evaluating the effectiveness and impact of care including the need for continued care or supports. In a person-centered system of care, the member has the primary decision-making role in identifying his or her need, preferences and strengths, as well as a shared decision making role in determining the services and supports that are most effective and helpful to them. A person-centered system requires the leveraging of existing community resources to support member needs and the involvement of the member's informal support system. Person-centered systems often require agreements with community organizations to provide peer navigators/mentors to address the non-medical needs of members. Most importantly, person-centered systems require direct "High-Touch," face-to-face contact throughout the care management process as discussed in Section 3.9 of this LOI between care managers/providers and the member. The Bidder must ensure that these values and requisites

prevail in the program for Rhody Health Options members. The person-centered system of care facilitates a partnership among the member, his/her designee, providers, and treatment team coordinators.

The following are illustrative key requisites of a person-centered system of care:

- Members participate in developing choices with respect to their services and supports, and must hold decision-making authority over which of the available services and supports to employ and which of the available providers to work with. Enrollees must not face any penalty or reduction in benefits for exercising freedom of choice.

- Members have control over who is included in the planning process.

- Members have choices about the extent of involvement of their PCP(s) in their individual care team and appeal processes (ranging from no involvement to acting on an individual's behalf for all care decisions).

- Members have the right to choose to designate someone (e.g. a family member, friend or care giver) to serve as their representative for a range of purposes or time periods. If a representative is needed at a point in time when an individual is too impaired to make a choice, the representative should be someone who has a history of close involvement with the person.

- Members are a part of the Multi-Disciplinary Care Management Team.

- Care planning meetings are held at a time and place that is convenient and accessible to the member.

- Health Plans provide information that allows a member to understand and make informed decisions about service options including providing information about *Olmstead*[4] rights to all individuals who use LTSS. Health Plans must also provide information about advance directives.

- Mechanisms are in place to minimize conflict of interests in the facilitation and development of the plan.

Person-centered systems of care emphasize self-direction, which is a service model that empowers public program participants and their families by expanding their degree of choice and control over the LTSS they need to live at home. Many members participating in a self-directing program share authority with or delegate authority to family members or others close

[4] The Supreme Court decision in Olmstead v. L.C. is a ruling that requires states to eliminate unnecessary segregation of persons with disabilities and to ensure that persons with disabilities receive services in the most integrated setting appropriate to their needs. More information is available at http://www.ada.gov/olmstead/index.htm.

to them. Designation of a representative enables minor children and adults with cognitive impairments to participate in self-directed programs.

Self-direction represents a major paradigm shift in the delivery of publicly funded home and community-based services (HCBS). In the traditional service delivery model, decision making and managerial authority is vested in professionals who may be either state employees/contractors or service providers. Self-direction transfers much (though not all) of this authority to participants and their families (when chosen or required to represent them).

Self-direction has two basic features, each with a number of variations. The more limited form of self-direction—which CMS refers to as employer authority—enables individuals to hire, dismiss, and supervise individual workers (e.g. PCAs and homemakers). The comprehensive model—which CMS refers to as budget authority—provides participants with a flexible budget to purchase a range of goods and services to meet their needs. Rhode Island utilizes both of these models.

The core feature of self-direction is the choice and control that participants have in regard to the paid personnel who provide personal care assistance services. This is because almost all participants receiving HCBS receive personal care assistance services and, for many, this is either the only or the primary service they use.

In Rhode Island, the self-directed program is called Personal Choice. The goal of the Personal Choice program is to provide a home and community-based personal care program where individuals who are eligible for LTSS have the opportunity to exercise choice and control (i.e., hire, fire, supervise, manage) individuals who provide their personal care, and to exercise choice and control over a specified amount of funds in a participant-directed budget. Participants choose a service advisement agency and a fiscal agent to assist in making informed decisions that are consistent with their needs and that reflect their individual circumstances. Additional information regarding the Personal Choice program is available in the procurement library at http://www.ohhs.ri.gov.

The Bidder is required to implement a self-directed model for members. The Bidder will work with EOHHS in adopting self-directed programs and in identifying the appropriate population groups and members to participate in a self-directed program.

In administering a self-directed model, the Bidder is required to continue to contract with the state's current subcontractors, PARI, Tri-Town, and Options for the first twelve (12) months of program operations to support self-directed members. These sub-contractors conduct on-line assessments, background checks on care givers as well as serve as a fiscal intermediaries and advisors to members. The Bidder will oversee and approve Plans of Care and personal budgets. The Bidder will indicate in the Care Management Plan how they perform these functions. After the first 12 month period, the Bidder is required to subcontract with organizations to perform fiscal intermediary responsibilities for members who receive self-directed supports and services. The Bidder has the option to enable the fiscal intermediary sub-contractor to perform care management functions and to conduct the re-assessments.

Rewarding Work (www.rewardingwork.org) is a website that provides an online registry of personal care assistants/individual support providers to people with disabilities and/or their families. Rhode Island is one of several States that has an agreement with Rewarding Work Resources, a 501 (c) (3) nonprofit corporation, to provide access to the Registry for Medicaid recipients enrolled in self-directed care programs. Rhode Island Medicaid recipients who are enrolled in the following programs receive free access to the worker registry on Rewarding Work:

- Personal Assistance Services and Supports (PASS)
- Respite for Children Program
- Personal Choice Program

In addition, entities that provide care management and care coordination to participants in the above programs have access to the Registry as well in order to assist participants in locating and hiring support staff. Rhode Island has participated in Rewarding Work since 2007 and there are currently 750 Medicaid recipients and/or their families who have memberships subsidized by this agreement and they have access to a pool of approximately 2800 workers from which to choose from.

The Bidder has policies and procedures to ensure that a person-centered system is maintained that will also be part of the Bidder's Care Management Program description.

3.8 Risk Profiling

The Bidder is required to have policies, procedures, practices and systems that identify Rhody Health Options members who require, who are "at risk" of requiring, and who may benefit from care management. Bidders must establish priorities regarding who receives care management as well as the amount and scope of care management members receive. The identification of members requiring care management occurs initially upon enrollment and continues throughout the care delivery process. The current Rhody Health Options population consists of individuals with varying medical, behavioral health and LTSS needs, and is in different care settings, and in different stages of their life. Consequently, members require different levels and types of care management. Conceptually, there may be members with Low Level, Medium Level, and High Level needs depending on the complexity of their conditions and the availability of their existing informal support network. Since care management resources are finite, Bidders must establish priorities and determine which population subgroups receive what type and level of care management. In essence, the Bidder must use a Predictive Modeling capability that identifies members with immediate care management needs and identifies those who are "at risk" of requiring care management and may benefit from care management. This type of assessment enhances positive healthcare outcomes as a result of interventions provided to members. A thorough analysis of claims data, encounter data or data from other systems over a two-year period can be used in Predictive Modeling. A risk score is used to establish the level and type of action or care management that is required. For example, some members may only require a Telephonic Initial Health Screen, others may require a Comprehensive Functional Needs Assessment, others may require the development of a Plan of Care, still others may require a Peer or Para-Professional Care Manager, while other members may require a Medical

or Social Work clinical professional Care Manager. A data "sweep" and subsequent analysis of the data to identify new members requiring care management assessment is conducted monthly.

The ability to intervene at any given point of time is most critical to the next treatment phase or to the outcomes of intervention on members. Member needs change throughout the care delivery process and thus their care management needs change. The Bidder must have an integrated system that tracks a member's condition and documents events (e.g. emergency room encounters, hospital admissions, nursing home admissions) that suggest a member requires care management. The system must provide the Care Managers with vital information in a timely fashion so that the appropriate interventions (e.g. care coordination, care management or modifications to existing services and supports, and/or Plan of Care changes) may be provided to improve a member's health care status and to avoid unnecessary use of limited resources.

3.9 Care Management

The mission of the ICI is to transform the delivery system through purchasing person-centered, comprehensive, coordinated, quality health care and support services that promote and enhance the ability of Medicaid-only and MME recipients to maintain a high quality of life and live independently in the community. Care management is a critical component of this strategy. EOHHS will build upon, improve and integrate with current Care Management programs to better meet the needs of the target population. Care should be less fragmented and more person-centered; care managers should strive to better communicate across settings and providers; and members should have greater involvement in their care management.

The goals of care management are to achieve the following:

- **Improve member health and quality of life** as indicated by: (1) improved quality of care and health outcomes for members, (2) ensured involvement of members and their families in the care management process, (3) promoting effective and ongoing health education and disease prevention activities, and (4) provide and coordinate support for family caregivers.

- **Decrease Care Fragmentation** as indicated by: (1) provide maximum physical and functional integration of care management through the primary care site, (2) facilitate access to timely, appropriate and person-oriented physical and behavioral health care, long-term services and supports, and other community based resources, (3) increase communication and coordination of care across all members of the care team, and (4) identify duplicative care management activities and the designation of a principle care manager.

- **Optimize Resource Utilization** by reducing avoidable emergency room visits, hospitalizations, and nursing home admission and lengths of stay.

Optimal care management requires a combination of three basic types of activities: (1) a set of "high-touch," person-centered, care management activities requiring direct interaction with the recipient and the care team, (2) data collection, analysis, interpretation, and

communication of data to the care team, and (3) monitoring and quality assurance of care management activities.

EOHHS believes that for certain individuals, person-centered care management activities are where possible, delivered in a manner that is functionally and physically integrated into a multi-disciplinary, primary care-based practice team with the capacity to support this function.

The Bidder is required to provide care management to Rhody Health Options members who are receiving community-based or institutional long-term services and supports. The Bidder is required to document those members who decline care management and the reasons for denial. The Bidder is also required to provide care management services to Rhody Health Options members who may benefit from care management such as members with complex medical conditions or members that exhibit "at risk" behaviors that may lead to institutional care or high cost services. The Bidder must establish an early warning system and procedure that fosters the early identification of "at risk" members and has the capability to identify member's emerging needs. The Bidder is also required to have effective systems, policies, procedures and practices in place to identify members in need of care management services.

Care management consists of nine major components: (1) Telephonic Initial Health Screen, (2) Comprehensive Functional Needs Assessment conducted face-to-face, (3) Designation of a Lead Care Manager, (4) Development of a Plan of Care, (5) Creation of a Multi-Disciplinary Care Management Team, (6) Conflict Free Case Management, (7) Implementation, Coordination and Monitoring of Plans of Care, (8) Transition Care Planning, and (9) Analysis of Care Management Effectiveness, Appropriateness and Patient Outcome. These components are discussed below.

Telephonic Initial Health Screen

The Bidder conducts a Telephonic Initial Health Screen on all new members not currently receiving LTSS within forty-five (45) days of enrollment and every one hundred and eighty (180) days thereafter, unless member conditions or needs dictate otherwise. Additionally, members receiving LTSS receive a Comprehensive Assessment as discussed below.

The Bidder uses a structured and standardized screening instrument to serve as a guide to conduct and to document the results of the Telephonic Initial Health Screen. The Telephonic Initial Health Screen explores the member's condition and need for care management services. The result of this assessment is to identify those members who require a Comprehensive Needs Assessment. The Bidder has policies and procedures governing the Telephonic Initial Health Screen Assessment including the instrument and the criteria to be used to select members who will receive a Comprehensive Functional Needs Assessment that is part of the Bidder's Care Management Plan and approved by EOHHS. EOHHS reserves the right to designate the screening tool.

Comprehensive Functional Needs Assessment

A Comprehensive Functional Needs Assessment is conducted in-person face-to-face for the three populations outlined below:

- **Members living in the community receiving LTSS.** An initial assessment is to be completed within fifteen (15) days of enrollment. The assessment is conducted in person. The in-person re-assessment is conducted every ninety (90) days or sooner if required based on the member's conditions or needs.

- **Members living in an institution.** An initial assessment is conducted within thirty (30) days of enrollment. The in-person re-assessment is conducted every one hundred and eighty (180) days or sooner if required based on the member's condition or needs.

- **Members living in the community who are not using LTSS but where determined to be "at risk" by the Health Plan and would benefit from care management during the Initial Health Screen.** A Comprehensive Functional Needs Assessment is conducted within fifteen (15) days after the Initial Health Screen indicates that a member will benefit from or at risk of requiring Care management. An in-person reassessment is conducted every ninety (90) days or sooner if required based on the member's condition or needs.

The Bidder has 180 days to complete all Comprehensive Functional Needs Assessments during the initial start-up period of this contract. Failure to meet this requirement will result in sanctions to the Health Plan.

The Bidder is required to provide a consultation and an Initial Health Screen within fifteen (15) days of a member's or caregiver's request.

For post-hospitalization, a home re-assessment must occur within five (5) days and adjustments to the Plan of Care will be made, as necessary.

The Comprehensive Functional Needs Assessment is conducted in-person face-to-face at the member's residence. A licensed clinician (e.g. Nurse, Clinical Social Worker) shall perform the assessment. The Telephonic Initial Health Screen can be conducted by a paraprofessional non-licensed staff person under the supervision and oversight of a licensed clinician.

The Comprehensive Functional Needs Assessment is a strengths-based and person-centered assessment that, at minimum, covers the following to determine a member's existing condition, level of needs and individual preferences:

- Medical history
- Functional status
- Mental health screen
- Cognitive functioning and dementia

- Alcohol, tobacco, and other drug use
- Nutritional status and food availability
- Medication management
- Social service needs (heating, food insecurity, etc.)
- Risk factors identification
- Identification of avoidable hospitalization or other high cost institutional care
- Housing
- Home Modifications (i.e. ramps, chairlifts)
- Informal support system
- Other service needs (e.g. legal)
- Need for specialized care management (e.g. for people with history of homelessness, people with intellectual or developmental disabilities, history of substance abuse, etc.)
- Home safety evaluation
- Family structure and social supports
- Well-being (self-report)
- How to report abuse and neglect
- Willingness or interest in vocational rehabilitation or future employment
- Self-identified areas of unmet needs and wants, such as transportation arrangements
- Information about advocacy agencies to support the member such as the State Ombudsman
- Information regarding statewide health information exchange: CurrentCare

State staff authorizes HCBS for a transitional period (may be thirty days) after determined to be eligible for LTSS and provides the Bidder with all relevant clinical and authorization materials to use in the Comprehensive Functional Needs Assessment conducted in the member's residence.

The Bidder is required to establish policies and procedures that govern the Comprehensive Functional Needs Assessment and level of care determination including an assessment tool that covers the topics noted above including the policies, procedures, practices, assessment tools and criteria used in needs assessments and level-of-care determinations. EOHHS must approve the policies, procedure and Comprehensive Functional Needs Assessment tool.

In conforming to the precepts of a person-centered system of care, the member, his/her care giver, and family takes an active role in identifying member conditions, strengths/weaknesses, and unmet needs.

Designated Lead Care Manager

The Bidder is required to ensure that every member receiving care management services has a Designated Lead Care Manager (Care Manager). The background, training and experience of the Lead Care Manager shall be determined by the member's principal needs. The Care Manager may be: a registered and licensed nurse for those members with complex and chronic medical conditions, a licensed and registered nurse with experience with members receiving

long-term care services, a licensed clinical social worker or counselor for members with behavioral health needs, or a peer navigator/care coordinator for members with social service needs. (A list of approved community based organizations that provide peer navigator services is noted in Appendix B). The Bidder has established and EOHHS approved minimum qualifications and experience for Care Managers. The Bidder has policies and procedures for assigning individual Care Managers to ensure an equitable distribution of workload. The Bidder also has established caseloads for the Care Manager based on the type of Care Managers and the population they serve. Caseloads are based on the varying needs of the different populations groups and the intensity of support required based on the intensity of their medical, behavioral health, and long-term needs and existing informal support system.

The Bidder establishes the role and responsibilities of each type of Care Manager for the different populations served. In some cases, the Care Manager may be required to provide intensive care management and care coordination relating to the provision of physical, behavioral health, and LTSS for members with complex medical conditions and chronic disorders. The Care Manager's responsibilities may include:

- Participate in development of a Plan of Care
- Refer members for care
- Follow-up with providers to obtain treatment results
- Provide health education including the proper use of medical resources including the emergency room
- Provide or link to self-management and disease management education
- Explain desired treatment results and outcomes
- Coordinate the delivery of medical, behavioral health care, and long-term care
- Track and monitor Plan of Care progress and achievement of treatment goals and objectives
- Review the Plan of Care periodically and make appropriate revisions in collaboration with the member and the member's provider(s)
- Assist providers in obtaining the necessary authorization to provide services, including access to alternative therapies
- Coordinate service delivery among all the providers associated in the member's care, and
- Provide other medically related support as well as social supports, to promote healthy outcomes

Some members may only require assistance in accessing support services, coordinating non-medical care or require a "peer mentoring" relationship. The responsibilities of these Care Managers may include:

- Assist with making appointments for health care services
- Cancel scheduled appointments if necessary
- Assist with transportation needs
- Follow up with members and providers to assure that appointments are kept
- Reschedule missed appointments

- Link members to alternatives to high-cost or intensive medical resources including the emergency room, when appropriate
- Assist members to access both formal and informal community-based support services such as child care, housing, employment, and social services
- Assist members to deal with non-medical emergencies and crises
- Assist members in meeting Plan of Care goals, objectives and activities
- Provide emotional support to members, when needed
- Serve as a role model in guiding the member to practice responsible health behavior

Members are able to receive care management through care management programs already available by the Bidder. In other cases, new Care Manager Positions may have to be developed. The Bidder shall review existing Care Manager staffing and propose the entire Care Manager capability that shall be available to Rhody Health Options program including the roles and responsibilities of the Care Managers for the different populations groups covered. The Bidder should indicate in its response to this LOI whether the Care Managers will be employees of the Bidder or employees of a sub-contractor.

The Bidders must employ only State licensed clinical staff for person receiving LTSS. Para-professionals or non-licensed staff may serve as Care Managers for members not receiving LTSS. The Bidder must designate the licensure, certification, and experience for the Care Managers for each of the populations they serve.

EOHHS maintains the right to approve the type of Care Managers, their background and experience, the populations they serve, their roles and responsibilities, and their caseloads.

Although it is advantageous for the lead Care Manager to be on-site in the PCP's office where practical, it is not required.

Plan of Care

The Bidder is required to ensure that a Plan of Care is developed and services are in place within five (5) days of completion of the Comprehensive Functional Needs Assessment for all Rhody Health Options members who receive Care Management. The Plan of Care reflects the needs of the member as identified in the Comprehensive Functional Needs Assessment. The Plan of Care is based on a structured predefined format prescribed by the Bidder that will also be flexible to document individual member needs. The development of the Plan of Care is a collaborative process with the member, his/her designee, Care Manager, PCP and other medical, behavioral health or social service providers, depending on the members' needs. The Plan of Care is comprehensive and documents the needs and interventions based on a member's medical, behavioral health, LTSS, social services and other critical needs (e.g. legal or housing) related to the member. The Plan of Care must reflect that members receive needed care and services through a seamless, person-centered and integrated system. The Plan of Care balances formal and informal community and family resources. The Plan of Care is personalized and built on member's strengths and preferences. The Plan of Care establishes the framework to integrate and coordinate the entire range of care required by the member.

The Plan of Care and its related processes advance the principles and tenets of the person-centered system of care. Examples of these principles and tenets include, but are not limited, to the statements listed below:

- The person-centered Plan of Care integrates all elements of needed medical, behavioral health, LTSS, and social service community living supports. An integrated care team has responsibility for developing and implementing the Plan of Care.

- The Plan of Care is prepared in person-first singular language and is comprehensible to the consumer and/or representative.

- In order to be strengths-based, the positive attributes of the member is documented at the beginning of the plan.

- The Plan of Care identifies risks and the measures taken to reduce risks without restricting the individual's autonomy to undertake risks to achieve goals.

- Goals are documented in the member's or their representative's own words and the amount, duration, and scope of services and supports is understood by the member.

- Specific person(s) and/or any provider agency responsible for delivering services and supports are identified.

- The Plan of Care includes a discussion of acute care preferences and anticipates care transitions needed for a return to the community from any temporary setting including the emergency room, a hospitalization, or a nursing home admission, as well as transitions requested by any individual who desires and is capable of a less restrictive community placement.

- Other non-paid supports and items needed to achieve the goal are documented. The Plan of Care includes the signatures of all people with responsibility for its implementation, including the individual and/or representative, and a timeline for plan review.

- The Plan of Care identifies the person and/or entity responsible for monitoring the Plan and everyone involved (including the member) must receive a copy of the Plan.

- The Plan of Care includes strategies for resolving conflict or disagreement within the process, and includes clear conflict-of-interest guidelines for all planning participants, as well as a method for the beneficiary to request revision of a plan, or appeal the denial, termination, or reduction of a service.

The following are topics that are covered in the Plan of Care, at a minimum:

- Member's physical and behavioral health status
- Primary and secondary diagnosis
- Functional needs and status
- Chronic conditions
- Short and long term goals, objectives, and expected outcomes
- Barriers to goals, objectives, and expected outcomes
- Medical interventions needed
- Disease and self-management interventions needed
- Medication Management
- Prevention and wellness interventions needed
- Interventions to address special needs (e.g. pain management, cognitive impairment, physical/vocational/speech therapy)
- Behavioral Health interventions needed
- Developmental disability services required
- Long-term interventions (institutional and HCBS)
- Informal support system interventions
- Emergency Back-Up Plan for members receiving LTSS
- Self-directed services and supports
- Social service interventions
- Other required interventions (e.g. housing, legal, recreational)
- Advanced Care Planning/Living Will
- Risk Mitigation Plan to address members' risk-factors for LTSS members

The Plan of Care identifies the amount, scope, intensity and duration of services and interventions. The Plan of Care will also indicate responsibilities for the coordination of care and the periodicity for review of Plans of Care. Copies of the Plan of Care are provided to members, his/her designee, Care Manager, PCP, BHDDH when appropriate, and other key providers.

The Bidder honors the service authorizations and providers used by members (including staying in the nursing home they reside in) enrolled in the Health Plan during the start-up period for the duration of the current service authorization. New members who are enrolled in the Health Plan after the initial start-up date will be required to use the Bidder's provider network.

The Bidder must comply with the benefits and related requirements for members who are enrolled in the Federal *RTH* demonstration grant. The Bidder must comply with the reporting requirements of that program so that EOHHS meets Federal demonstration requirements. Details regarding the *RTH* demonstration grant are discussed later in this document and in the operational protocol governing the demonstration that is contained in the Procurement Library.

The Bidder is required to establish Plan of Care policies, procedures and practices including the development of a standardized, flexible and informative Plan of Care format. The Bidder will

also have procedures to monitor the development of Plans of Care including reviewing a representative sample of Plans of Care to ensure that requirements are met, and to take appropriate action to remedy issues. Bidders will have procedures in place to monitor and follow up on the implementation of Plans of Care. This process includes mechanisms to ensure that paid and unpaid services and supports are delivered, and that integrated care teams monitor progress toward achieving individuals' goals, and review the care plan according to the established timeline. The Bidder must provide a mechanism for the individual to report feedback on progress, issues and problems. The Bidders policies, procedures and practices related to Plans of Care must be approved by EOHHS.

Multi-Disciplinary Care Management Team

A Multi-Disciplinary Care Management Team (Care Management Team) is assembled to meet the member needs as identified in the Comprehensive Functional Needs Assessment and the required intervention services and supports noted in the Plan of Care. The Care Management Team may consist of all or some of the following individuals:

- Member
- Family member and care givers, at the discretion of the member
- Lead Care Manager
- Other Care Managers
- Peer Navigator
- Pharmacist
- PCP
- Behavioral Health Specialist, if appropriate
- Therapists, if appropriate,
- Long-term care provider(s), if appropriate
- Other key medical specialists or human service providers, if appropriate

The Bidder must establish policies, procedures and practices to ensure the assembly and proper functioning of a Care Management Team to meet the needs of members, including the frequency of Care Team meetings. The Bidder also ensures that Care Management Team meetings are conducted at times and locations that considers the members' circumstances. EOHHS reserves the right to approve the policies, procedures and practices related to the Care Management Team and the establishment and functioning of Care Management Teams.

The Bidder must establish policies and procedures for the establishment of care management ratios that take into account the risk profile of the enrolled population that reflects:

- Need for interpreters
- Case mix
- Need for acute services
- Travel time
- Lack of family and social support
- Other factors deemed appropriate by the Bidder

New members may have been receiving primary care services through a PCMH site. Where possible, the Care Managers at those sites should be an integral part of the Care Management Team for those members. Bidders' responses should indicate how the Care Management Team will continuously inform the provider team regarding the Plan of Care and the authorization of LTSS in the home.

Bidders will be required to subcontract with a community-based organization to provide peer navigator services that meet EOHHS specified performance requirements and meet the performance standards in the Model Contact.

Conflict Free Case Management

EOHHS intends to submit an application to CMS for the Balancing Incentive Program (BIP). BIP requires States to develop, as part of their No Wrong Door/Single Entry Point (NWD/SEP) systems, conflict free case management services. Conflict-free case management has the following characteristics:

- ***There is separation of case management from direct services provision***: Structurally or operationally, case managers should not be employees of any organization that provides direct services to the individuals. Ideally, conflict-free case management agencies are stand-alone and provide no other direct services. This prevents financial pressure for case managers to make referrals to their own organization or the "trading" of referrals.

- ***There is separation of service eligibility determination from direct services provision***: Eligibility for services is established separately from the provision of services, so assessors do not feel pressure to make individuals eligible to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual.

- ***Case managers do not establish funding levels for the individual:*** The case manager's responsibility is to develop a plan of supports and services based on the individual's assessed needs. The case manager cannot make decisions as to the amount of resources (individual budget, resource allocation, or amount of services).

- ***Individuals performing evaluations, assessments, and plans of care cannot be*** related by blood or marriage to the individual or any of the individual's paid caregivers, financially responsible for the individual, or empowered to make financial or health-related decisions on behalf of the individual.

Successful Bidders must demonstrate that their Care Management programs contain the necessary elements of conflict free case management.

Implementation, Coordination and Monitoring of the Plan of Care

The lead Care Manager is responsible for executing the linkages and monitoring the provision of needed services identified in the Plan of Care. This includes making referrals, coordinating care, promoting communication, ensuring continuity of care, and conducting follow-up.

Implementation of the member's Plan of Care will enhance his/her health literacy while being considerate of the member's overall capacity to learn, and (to the extent possible) assist the member to become self-directed and compliant with his/her Plan of Care. Critical components of the care coordination/implementation process will:

- Refer members to services
- Track and follow-up on care
- Serve as a "communication hub" in the coordination of care between primary care, specialty care, behavioral care, institutional care, LTSS and end of life care
- Communicate and refer to community-based resources
- Support transitions from hospital to community or nursing home to community
- Provide member education and self-management support
- Collaborate with providers
- Utilize behavior change techniques and motivational interviewing practices
- Coordinate medication management with a pharmacist,
- Coordinate the provision of community-based services and supports
- Refer as appropriate to end-of-life services and supports
- Monitor changes in member's conditions and needs
- Monitor the impact of services and care, and the need for continued or additional services

Monthly telephone contact is required for members receiving care management services. Quarterly home visits are required with one (1) home visit annually is be unannounced. Home visits for RIte @ Home members are conducted monthly.

The lead Care Manager must establish an Emergency Back-Up Plan that will provide support to members twenty-four (24) hours per day and seven (7) days per week. The Back-Up Plan identifies key people or agencies that the member should contact when there is a disruption in the on-going support that is provided to them so that they remain safe and able to function in the community. The Care Manager may utilize the individual's informal or formal supports to comprise initial emergency back-up procedures for the individual. Additionally, the Bidder must assist in obtaining emergency services and supports in urgent cases where the disruption in the on-going support that is provided to the individual has placed him or her at risk.

The Bidder must coordinate with providers the provision of all out-of-plan services. The bidder is expected to coordinate behavioral health services with providers who are funded by BHDDH for members with SPMI and members with developmental disabilities. Section 2.07 of the Model Contract describes the Bidder's coordination responsibilities.

The Bidder uses existing data and analytic capacities to: identify the changing needs and risks of members; stratify members' needs according to acuity and risk for hospitalization or nursing home placement; communicate with Care Management Teams regarding high risk members; and ensure that members receive appropriate, timely and comprehensive Care Management services. An essential component is the ability to modify members' Plans of Care to ensure the appropriateness of service delivery. The Bidders must apply systems,

science, and information to identify members with potential Care Management needs and assist members in accessing Care Management services with the goal of improving and maintaining quality of life.

The Bidder is responsible for monitoring and ensuring the quality and effectiveness of Care Management activities in multiple ways, including contractual arrangements with PCPs, community health and social service resources or other entities providing integrated Care Management services. The effectiveness of the Care Management process is measured by the review and analysis of patient outcomes. Bidders are expected to develop processes to collect and submit population based measures to the State quarterly for review. State approved measures must be used to monitor success.

Management of Care Transitions

Success of this program depends on the ability of the Bidder to manage the transition of members when they move across care settings, such as:

- Hospital to nursing home
- Hospital to home/community
- Nursing home to hospital
- Nursing home to community
- Community to nursing home
- Community to hospital

Models for care transitions exist throughout the nation (e.g. The Coleman Care Transitions Intervention program is based on the work of Eric Coleman, MD, from the University of Colorado). The Bidder must adopt or modify existing approaches to care transitions or develop their own to ensure effective transitions and the continuity of care when members move between care settings and levels of care. A key in care transitions is to have effective strategies that prevent members from moving to a higher level of care, when it is avoidable.

To successfully transition a member across settings, Care Management and support during transitions must be available twenty four hours a day, seven days a week (24/7). This includes a transitional Care Management program that provides onsite visits with the Care Manager upon discharge from hospitals, nursing homes, or other institutional settings. Care Managers will assist with the development of discharge plans. Transitional Care Management reflects Rhode Island's best practices in hospital transitions of care, by requiring the Bidder to incorporate experiences, lesson learned and best practices from *RTH* and the Nursing Home Transition Program.

The Bidder must have policies, procedures and practices for transitioning members between levels of care and care settings that are approved by EOHHS.

Analysis of Care Management Effectiveness, Appropriateness and Patient Outcomes

The Bidder is responsible for monitoring and ensuring the quality and effectiveness of Care Management activities in multiple ways, including through contractual arrangements with PCPs, community health workers or other entities providing integrated care management services. Expectations for Care Management activities will be developed by EOHHS. Each member with Care Management needs must have a Plan of Care that addresses his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction.

The effectiveness of the Care Management process is measured by the review and analysis of patient outcomes. The Bidder develops processes to collect and submit population based measures to EOHHS quarterly for review on Medicaid only and MME members. EOHHS approved measures are used to monitor success.

The Bidder has effective systems, policies, procedures and practices that govern the Care Management process. The Bidders are expected to have integrated electronic information systems that maximizes interoperability in order to provide Care Managers with access to all essential data related to the member (including but not limited to: member's clinical history, diagnosis, sentinel events, urgent/ongoing care need). Other data sources (pharmacy, utilization) and data mining tools (predictive modeling, risk scores) may be used to: (1) place a Member into his/her appropriate Care Management model (for that particular date in time); (2) implement his/her Plan of Care; (3) monitor Plan of Care for effectiveness and appropriateness; and (4) modify the Plan of Care to accurately reflect any change in the member's circumstances. Strong consideration should be given to the use of the State's Health Information Exchange, **Current*care***, to support information exchanges, particularly around care transitions.

3.10 Nursing Home Transition Members, including *Rhode to Home* Participants

The Bidder establishes policies, procedures and practices for Medicaid recipients who are participating in the *Rhode to Home* demonstration program, and other nursing home transition members. The Procurement Library contains the CMS approved *Rhode to Home* (MFP) Operational Protocol that the Bidder must comply with. The following describes the process flow currently used in the Nursing Home Transition Program and *Rhode to Home* demonstration grant for individuals transitioning from nursing homes to community-based residences.

***Rhode to Home* Eligibility**

Eligibility for the *Rhode to Home* (*RTH*) demonstration is regulated by Federal requirements and final approval of all potential *RTH* enrollees is conducted by EOHHS. The Bidder must follow EOHHS's policies and procedures related to the *RTH* eligibility process. To identify potential *RTH* participants prior to transition, the Bidder must confirm the following criteria have been met and submit the appropriate documentation to the State for approval (as established by the State). A member must meet initial enrollment eligibility criteria:

- Reside in a nursing home for at least 90 consecutive days (the days may not include those days that were for the sole intent and purpose of receiving short term rehabilitation, reimbursed by Medicare).

- Be Medicaid eligible (at least one day immediately prior to discharge); and (1) once the above criteria have been met, the Bidder must inform the member about the *RTH* demonstration grant, and (2) obtain an informed consent to participate in the *RTH* demonstration which is signed by the Member or their legal guardian (if applicable).

- The Bidder reports to EOHHS for review and approval, a list of all potential *RTH* participants that meet the initial enrollment criteria outlined above. EOHHS establishes all reporting requirements for initial enrollment.

- EOHHS will provide verification of enrollment status for those members that meet all criteria for initial enrollment in the *RTH* demonstration grant. Members that meet all initial enrollment criteria and have been verified by the State as eligible for enrollment will be deemed "RTH Enrollees".

The specific criteria to determine a member's eligibility to participate in the MFP demonstration grant include:

- The member must move to a *RTH* qualified residence that meets the requirements established by the EOHHS. Qualified residences include: (1) an individual's home, or apartment like setting that includes areas for sleeping, bathing, living and eating, (2) the home or apartment must be owned or leased by the individual or their caregiver or family member; and (3) the home may be a group home where no more than four individuals reside.

- Additional qualifying criteria may also apply such as: (1) the individual must have the right to choose their service provider; and (2) unless otherwise assessed and identified as a need within the individual's Plan of Care, the residence must offer unrestricted access to the areas within the residence; cannot require notification of absences; and cannot reserve the right to assign apartments or change apartment assignments.

- EOHHS establishes all required documentation for participation in the *RTH* Demonstration. EOHHS will provide verification of participation status for those members that meet all criteria for participation in the *RTH* demonstration grant. Members that meet all participation criteria and have been verified by EOHHS as eligible for participation will be deemed "*RTH* Participants".

- The Bidder forwards all required documentation to the EOHHS at periodic intervals established by the EOHHS. Intervals established by the EOHHS may include, but are not limited to: pre-transition (length of stay in the nursing home, Medicaid eligibility status, and signed consent); immediately after transition (residence documentation); and ongoing care coordination (includes but is not limited to: progress and ongoing review, critical incidents, 24/7 back-up plan and all additional documentation and required reporting as established by the State).

- EOHHS determines and provides notification to the Health Plan, when an individual's participation in the *RTH* demonstration grant ends.

Referrals from Minimum Data Set 3.0 Section Q (MDS Section Q)

The Bidder receives referrals from the nursing home regarding those individuals who indicated through the MDS Section Q that they are interested in learning more about LTSS that may be available in a community based residence. The Bidder utilizes the information to identify individuals who are interested in receiving Long Term Care Options Counseling (LTC Options Counseling) and reports all MDS Section Q referrals received to the State in a manner established by EOHHS.

LTSS Options Counseling

The Bidder coordinates with the State's Aging and Disability Resource Center (ADRC) to ensure that LTC Options Counseling is provided to members who were referred through the MDS Section Q process as well as other independent referrals received for individuals living in institutions and community based residences. LTC Options Counseling is provided in a manner that: (1) is consistent with the practice established by and provided by State representatives; and (2) utilizes materials and supports established by and/or approved by the state.

Nursing Home Referrals

The Bidder proactively reviews data to identify those individuals that have resided in a nursing homes or other specified institutions that are likely candidates to transition to a community based residence and could potentially receive community-based care. The Bidder conducts a screen of potential candidates who desire to transition to a community-based residence and may be eligible to receive home and community-based care.

- For members that have resided in a Nursing Home for 90 days or longer, the Bidder assesses the individual every 6 months for possible transition. The Bidder must provide documentation to the state, if the individual, individual's guardian or responsible party determine that ongoing assessments are not appropriate.

- The Bidder provides documentation and reports, in the manner established by the state, on all members assessed, the potential ability to transition, barriers to potential

transition, and any additional criteria established by the State.

- A Plan is developed to provide LTC Options Counseling and information for potential transition to a community-based residence.

- Other information is reviewed such as, but not limited to: the patient's length of stay in the facility, assessed needs, the individual's eligibility status for Medicaid, the individual's preferred or potential home and community-based residence including any applicable rental leases as well as other screening criteria established by EOHHS.

This information is submitted to EOHHS.

Affordable Housing

The Bidder must develop policies and procedures to identify affordable housing options for members that are interested in transitioning from nursing homes (and other institutions as specified by the State). The Bidder supports members to identify:

- Affordable apartment units listed within Public Housing Authorities

- Tenant-based rental assistance and voucher programs

- Opportunities for members to reside in a home or apartment with a caregiver or family member

- Supportive housing models including but not limited to: Assisted Living Residences with affordable units including those that participate in the State's Assisted Living Waiver program, subsidized housing options with personal care assistance and behavioral health supports

- Other affordable housing options including but not limited to low income housing tax credit programs

The Bidder must hire a Housing Specialist to assist members who are interested transitioning from a nursing home to a community-based residence. The Housing Specialist will utilize resources of affordable housing options available to individuals across the State. Resources should include web-based housing search tools such as HomeLocatorRI.net, Rite Resources, SocialServe.com, and written materials for the individual to use in choosing a housing model. The Housing Specialist discusses with members varying housing alternatives and assists the member to choose a suitable residence that is safe and meets their needs. The Housing Specialist works with the Transition Coordinator in assessing the suitability of housing options.

The Housing Specialists must have knowledge and experience in working with housing entities and advocating for individuals' rights in landlord-tenant general contracting practices. General knowledge and experience includes: expertise in fair housing regulations, tenant-landlord rights and reasonable accommodation requests. Additionally, Housing Specialists are familiar with community-based LTSS that can be provided in the varying housing models to help support individuals residing in the community.

Transitioning Process to a Community-Based Residence

The Bidder designates a lead staff person to serve as a Transition Coordinator. The Transition Coordinator responsibilities are to ensure the following process occurs.

- **Conduct a Comprehensive Clinical Assessment** that includes but is not limited to: a clinical assessment conducted by a registered nurse, a social services assessment containing a psychosocial evaluation, and a risk assessment.

- **Develop a Person-Centered Plan of Care** to address all of the individual's LTSS needs that will be provided once they transition to a community-based residence. The person centered Plan of Care includes but is not limited to services and care to be provided, clinical and non-clinical supports and services, a risk mitigation plan, and a 24/7 emergency back-up plan.

- **Transition Coordination and Care Management** is provided based on the specifications outlined below, for at least 365 days after the date of transition. Care Management is provided in a manner that meets the individual's varying medical and non-medical needs. Care Management includes non-traditional or specialized care management when needed by the member. The Bidder's care management policies, procedures and practices are approved by EOHHS. The Bidder is required to have systems in place to track and document the provision of services and care management provided to members throughout the transition process.

  The Bidder is required to conduct face-to-face visits based upon the following minimum criteria (or more frequently based upon individual's need): (1) conduct a face-to-face visit in the individual's home on the date of discharge from the nursing home, (2) weekly visits and/or phone contact in the community beginning the first month of transition with a minimum of two face-to-face visits, (3) monthly visits and/or phone contact during month two through twelve after the individual transitions to a community based residence. The frequency of face-to-face visits or phone contact occurs with members based on their individual needs. For *RTH* participants, monthly visits and/or phone contact continues until the State notifies the Health Plan of the end date of *RTH*

participation.

The Transition Coordination and Care Management period begins once the member transitions to a community-based residence and continues for 365 days while the member lives in the residence. A member's transition period may extend beyond 365 consecutive days if the individual experiences an interruption in their community support services due to hospitalization, critical incident, or other extenuating circumstances.

The care management process also includes, but is not limited to, ensuring that a member's specialized service needs (e.g. physical disabilities, intellectual and/or developmental disabilities, veterans with disabilities, elders with dementia, mental health and substance abuse illnesses, chronic homeless, caregiver support) are met so that members have the ability to live safely and independently in the community.

- **Ongoing Care Management** is provided once the individual completes the Transition Coordination and Care Management period. The member begins receiving ongoing Care Management as established in the prior Section 3.9. For *RTH* participants, ongoing Care Management is provided once the State notifies the Health Plan of the individuals end date of *RTH* participation.

- **Quality of Life** surveys must be conducted for all members transitioning from nursing homes, and other institutions as defined by the State, to community-based residences to ensure that they are receiving the services and supports they need to maintain the quality of life they desire.

The Bidder will contract with the Alliance for Better Long Term Care to perform Quality of Life surveys for all approved RTH transition cases, in the manner established by the State and utilizing the Quality of Life survey tool approved by the State. For those transitions that are not approved *RTH* cases, the State will conduct the Quality of Life surveys.

For members transitioning from nursing homes to community-based residences, Quality of Life surveys are required to be conducted three (3) times per individual: at least three (3) days prior to transition, eleven (11) months post discharge from the nursing home, and twenty-four (24) months post discharge from the nursing home. For *RTH* cases, the results of the Quality of Life survey must be reported to the State in the manner established by the State.

Additional Services

The Bidder provides Peer Navigator/Peer Mentor services to meet members needs who do not

require complex high level clinical support but require assistance and peer mentoring to access community services such as persons: with SPMI and developmental disabilities; who are elderly; with a history of homelessness, who have been identified as a veteran, and other possible specialized needs that may be identified on an individualized basis.

Critical Incidences

For Nursing Home Transition members, EOHHS reviews and monitors critical incidents that impact the individual during their Transition Coordination Care Management phase. The Bidder must submit documentation, in the manner established by EOHHS, on all critical incidents such as: hospitalizations, emergency room visits, medication errors, neglect, self-neglect, exploitation, police involved incidences, and disasters that result in recipients being displaced from their homes. EOHHS establishes the requirements for critical incident documentation, review, and ongoing monitoring process. The Bidder reviews all critical incidents as they are reported to ensure the member remains safe in their home environment including the circumstances surrounding the critical incident and the continued needs of the member.

For *RTH* Participants, the State currently contracts with the Alliance for Better Long Term Care to report all critical incidents such as: hospitalizations, emergency room visits, medication errors, police involved incidences, and disasters that result in recipients that are displaced from their homes. For all *RTH* qualified participants, the Bidder is required to contract with the Alliance for Better Long Term Care to continue to report these critical incidences to the Health Plan in the manner established by the State.

Home and Community Care Emergency Back-up Plan

For members transitioning from an institutional setting to a home and community based setting, the Transition Coordinator must establish an Emergency Back-Up Plan that will provide support to the individual twenty-four (24) hours per day and seven (7) days per week. The Back-Up Plan identifies key people or agencies that the member should contact when there is a disruption in the on-going support that is provided to them so that they remain safe and able to function in the community. The Transition Coordinator may utilize the individual's informal or formal supports to comprise initial emergency back-up procedures for the individual. Additionally, the Bidder must assist in obtaining emergency services and supports in urgent cases where the disruption in the on-going support that is provided to the individual has placed him or her at risk.

For *RTH* members, The Alliance for Better Long Term Care (the Alliance) functions as the third or final level of back up in emergency situations as established by the Transition Coordinator. In this role, the Alliance will work with the member in determining the severity of their situation, identify the steps the member took prior to calling the Alliance and provide the necessary support or service to meet the member's needs. For all *RTH* qualified participants, the Bidder is required to contract with the Alliance to continue to report usage and actionable occurrences under the 24/7 emergency backup plan to the Bidder in the manner established by EOHHS.

Reports to EOHHS

The Bidder is required to report on all Nursing Home Transition and *RTH* members as required by EOHHS including but not limited to information related to: referrals, assessments, Plans of Care, transitions, residence information, service provision and care coordination, risk and mitigation plans, critical incidences, 24/7 emergency back up plans, service outcomes, Care Management progress and review updates, service and supports encounter data and other information required by EOHHS and in the prescribed frequency and formats.

EOHHS Support

EOHHS will designate a staff person to work with the Health Plan in implementing and operating the Nursing Home Transitions Program (NHTP) and *RTH* demonstration grant. The State is prepared to share its policies, procedures, protocols and tools, and report systems currently employed in the NHTP and *RTH* demonstration grant as well as train Health Plan staff.

The bidder will designate a staff person to work with EOHHS to implement and ensure ongoing compliance with all transition and documentation requirements outlined in Section 3.10

3.11 Member and Provider Services

The Bidder must meet the requirement in Sections 2.10 and 2.11 regarding Member and Provider Services, respectively. As part of its Member Services function, the Bidder must have an ongoing program of member education that takes into account the multi-lingual, multi-cultural nature of the population and also recognizes that some members have disabilities.

The Bidder staffs a Member Services function to be operated at least during regular business hours (8 AM to 6 PM including lunch, Monday through Friday) and to be responsible for the functions identified in the Model Contract. During the initial first four month start up period, the Member Services function will be operated from 8 AM to 8 PM including lunch, seven (7) days a week. The Bidder maintains a toll-free Member Services telephone number that is staffed twenty-four (24) hours per day to provide prior authorization of services during evenings and on weekends.

Once a year, the Bidder must notify members in writing of their rights to request and obtain information about: their benefits, out-of-plan services, freedom of choice provider restrictions, State and Health Plans grievance and appeals processes, after hour and emergency coverage, services authorization requirements, referrals for specialty care, and other information as identified in Section 2.10 of the Model Contract.

The Bidder staffs a Provider Services function, to be operated at least during regular business hours and to be responsible for the functions identified in the Model Contract. As part of its Provider Services function, the Bidder has an ongoing program of provider education concerning Rhody Health Options benefits and the needs of the member population. The provider education program includes a quarterly provider newsletter.

The Bidder requires providers to report any changes in address or telephone numbers at least thirty (30) days prior to the change occurring.

3.12 Medical Management and Quality Assurance

The Rhode Island Department of Health regulates the Utilization Review and quality assurance, or quality management (UR/QA) functions of all licensed Health Plans. The Bidder, therefore, complies with all Department of Health UR/QA standards, in addition to specific standards described in this section.

The requirements for medical management and quality assurance are described in Section 2.12 of the Model Contract and highlighted below.

Medical Director

The Bidder designates a Medical Director responsible for the development, implementation, and review of the internal Quality Assurance Program (QAP). The Medical Director is licensed to practice medicine in the State of Rhode Island and be board-certified, board-eligible, or board-trained in his or her field of specialty. The Medical Director is responsible for:

- The Bidders Utilization Review and Quality Assurance Committees
- Development of medical practice standards and protocols for Bidder
- Overseeing the investigation of all potential quality of care problems
- Oversight of Bidder's Care Management programs
- Development of Bidder's medical policies
- Referral process for specialty and out-of-plan services

The Medical Director is involved in: (1) recruiting and credentialing activities, (2) the process for prior authorizing and denying services, (3) the development and oversight of the Bidder's disease management programs, and (4) the process for ensuring the confidentiality of medical records/client information. The Medical Director serves as the Health Plan's liaison with its provider community.

Utilization Review

The Bidder must have written policies and procedures to monitor utilization of services by its members and to assure the quality and accessibility of care being provided in its' network. The policies and procedures must: (1) conforms to 42 CFR 438.350, (2) assure that the UR and QA Committees meet on a regular schedule, (3) provides for regular UR/QA reporting to the Health Plan's management and providers, including profiling of provider utilization patterns.

The policies and procedures include protocols for: denial of services, prior approval, hospital discharge planning, physician profiling, and retrospective review of claims. The Bidder is

expected to at minimum meet the limits for minor assistive devices and home modifications as described in Attachment A: In-Plan Services of the Model Contract. As part of its utilization review function, the Bidder has processes to identify utilization problems and undertake corrective action. The Bidder has a structured process for the approval or denial of covered services. This includes, in the instance of denials, formal written notification to the member and the requesting or treating provider that includes the basis for the denial, and any applicable appeal rights and procedures including EOHHS level appeal within fourteen (14) days of the request for authorization. The Bidder demonstrates to the EOHHS that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically or functionally necessary services to any member. The Bidder may engage in direct discussions and/or patient or patient family interviews, as necessary, in order to facilitate discharge planning, consider treatment options or alternatives, and the like for cost-effective, patient-centered medically necessary care. These direct discussions may be used to assess the medical and/or mental health status of a patient.

The Bidder establishes a Medicaid Pharmacy Home Program for all populations to restrict members whose utilization of prescriptions is documented as being excessive. For Phase I, members are "locked-in" to a specific pharmacy in order to monitor prescriptions received and reduce unnecessary or inappropriate utilization. The Bidder agrees to provide ample notification to members regarding pharmacy lock-in. Specific criteria will be provided to the Bidder by EOHHS.

The Bidder shall accept and honor the authorizations that were made prior to the contract commencement date until the authorization period has ended.

Quality Assurance

The Bidder has a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas including all subcontractors. Emphasis is placed on, but need not be limited to, clinical areas relating to management of chronic diseases, mental health and substance abuse care, members with special needs, and access to services for members.

The Bidder is required to undertake several Quality Improvement Projects (QIPs) during each contract year. EOHHS may specify the focus area for the QIP. The Bidder reports the status and results of each project to the EOHHS, or its designees, as requested, at least within thirty (30) days following presentation to the Bidder's Quality Improvement Committee. The Bidder will cooperate fully with the EOHHS or its designees in any efforts to validate QIPs. Each QIP is completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.

The Bidder supports joint quality improvement projects involving Health Plans and EOHHS and provides Medicaid HEDIS® and CAHPS® results to EOHHS, or its designees, within thirty (30) days of receipt of final audited results from NCQA. The Bidder has defined protocols that

require routine reporting on the quality of care (e.g., timeliness for conducting the Initial Health Screen) and access to services (e.g., access barrier analysis).

Confidentiality

The Bidder has written policies and procedures for maintaining the confidentiality of data, including medical records/client information and sexually transmitted infections (STI) appointment records that conform to HIPAA requirements.

The Bidder agrees to make available to the State and/or its designees on a periodic basis, medical and other records for review of quality of care and access issues.

Practice Guidelines

The Bidder will develop (or adopt) and disseminate practice guidelines that comply with 42 CFR 438.236 and: are based on valid and reliable medical evidence or a consensus of health professionals in the particular field, consider the needs of members, are developed in consultation with contracting providers, that are reviewed and updated periodically as appropriate. The Bidder will disseminate the guidelines to all affected providers and, upon request, to members and potential members. Decisions for utilization management, member education, coverage of services, and other areas to which the practice guidelines apply must be consistent with the practice guidelines.

Service Provision

The Bidder will provide services in the amount, duration, and scope of service in a manner that is expected to achieve the purpose for which the services were provided. The Bidder may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.

Provider Credentialing

The Bidder has written credentialing and re-credentialing policies and procedures for determining and assuring that all providers under contract to the plan are licensed by the State, or state in which the covered service is furnished, and are qualified to perform their services. The Bidder also has written policies and procedures for monitoring its providers and for disciplining providers who are found to be out of compliance with Bidder's medical management standards.

The Bidder must have a uniform credentialing and re-credentialing process and ensure that the process complies consistently with State regulations and current NCQA "Standards and Guidelines for Accreditation of Health Plans". For organizational providers including nursing

facilities, hospitals, and Medicare certified home health agencies, the Bidder must adopt a uniform credentialing and re-credentialing process and that consistently complies with State regulations.

The Bidder does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. The Bidder agrees not to employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act.

The Bidder has written policies and procedures which pertain to disclosures by providers. In accordance with 42 CFR Section 455.104, disclosures must be obtained from any provider or disclosing entity at any of the following times: when submitting a provider application, when executing a provider application, upon request during re-validation or re-credentialing process, within thirty-five (35) day of any change in ownership.

Providers must disclose any individual who has ownership (i.e. five percent or more) or interest in the provider that has been convicted or a criminal offense.

The Bidder may refuse to enter into, or renew, an agreement with a provider if any person: who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any Federal health care program. The Bidder may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure as required in this section and in the Model Contract. The Bidder promptly notifies EOHHS of any action that it takes to deny a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on the Bidder's concern about Medicaid program integrity or quality.

The Bidder also promptly notifies EOHHS of any action that it takes to limit the ability of an individual or entity to participate in its program, regardless of what such an action is called, when this action is based on the Bidder's concern about Medicaid program integrity or quality. This includes, but is not limited to, suspension actions and settlement agreements.

3.13 Operational Data Reporting

The Bidder must comply with Section 2.13 of the Model Contract. The Bidder provides EOHHS with uniform utilization, quality assurance, and member satisfaction/complaint data on a regular basis, described below, and additional data in a manner acceptable to the State. Record content must be consistent with the utilization control requirement of 42 CFR 456.111. The utilization review plan must provide that each member's record includes information needed for the Utilization Review Committee to perform required utilization review activities. The Bidder also agrees to cooperate with the EOHHS in carrying out data validation activities.

The Bidder agrees to provide, for each member, a person-level record describing the care received by that individual during the previous quarterly period. In addition, Bidder provides aggregate utilization data for all members at such intervals as required by EOHHS. The

person-level record includes, at a minimum, those data elements listed in the *Encounter Data Business Design* including updates issued by EOHHS' designated Medicaid Management Information System ("MMIS") contractor. The Bidder submits data in an electronic or tape format that conforms to the State's specifications.

The Bidder submits person level records quarterly or more frequently as determined by EOHHS and no more than ninety (90) days past the end of the reporting quarter. The Health Plan submits aggregate data quarterly and no more than one hundred eighty (180) days past the end of the reporting quarter and assists EOHHS in its validation of utilization data by making available medical records and a sample of its claims data.

The Bidder also: (1) submits a quarterly grievance and appeals report due no later than thirty (30) days after the end of the reporting quarter, (2) submits internal quality assurance reports periodically, (3) collects member satisfaction data through an annual survey of its members, (4) submits a quarterly fraud and abuse report due no later than thirty days after the end of the reporting period, and (5) quarterly pharmacy claims information with respect to Drug Rebate Equalization in a format that is compliant with CMS published guidelines and approved by EOHHS.

The Health Plan's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the Health Plans CEO or CFO must certify the data. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of the data and the documents submitted to EOHHS. The Bidder complies with standards and operating rules of the ACA.

3.14 Grievance and Appeals

The Bidder must meet the requirements governing the grievance and appeals process as described in Section 2.14 of the Model Contract.

The State has established a Grievance and Appeals function through which members can seek redress against Health Plans. The grievance system includes a grievance process, an appeals process, and access to the State's Fair Hearing system. EOHHS requires that Health Plans resolve member and provider complaints through internal mechanisms whenever possible.

The Bidder's policies and procedures for processing grievances permits a provider, acting on behalf of a member and with the member's written consent, to file an appeal of an action within 30 days from the date on the Health Plans Notice of Action. An Action means: (1) whether or not a service is a covered Service; (2) the denial or limited authorization of a requested service, including the type or level of service; (3) the reduction, suspension, or termination of a previously authorized service; (4) the denial, in whole or in part, of payment of a service; (5) the failure to provide or authorize services within a timely manner, or (6) the failure of the Health Plan to act within prescribed time frame as indicated in the Model Contract. The information that is required to be in a Notice of Action is also included in the Model Contract. The time frames for mailing a Notice of Action must comply with 42 CFR 438.404. The Health Plan also

notifies the requesting provider of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

A grievance is a formal expression of dissatisfaction about any matter other than an "action". Members may file a grievance with the Bidder either orally or in writing. The Bidder must address each grievance and provide notice in writing, as expeditiously as the member's health condition requires, within ninety (90) days from the day the Contractor receives the grievance.

For appeals, the process must: (a) provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution; (b) provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing; (c) provide the member and his or her representative opportunity, before and during the appeals process, to examine the case file, including medical records and other documents and records considered during the appeals process; under certain circumstances certain categories of medical records and other documents may not be available to the member based on the type of record including but not limited to mental health records; and (d) include, as parties to the appeal, the ember and his or her representative, or the legal representative of a deceased member's estate. The Health Plan provides written notice of the disposition of all appeals within thirty (30) days from the time the Health Plan receives the appeal. For notice of an expedited appeal, Health Plan must also make reasonable efforts to provide oral notice. The information that is required to be in the written notice is indicated in the Model Contract. The Health Plan must continue to provide services during the appeals process if the member filed for an appeal within ten days of the Notice of Action.

The Health Plan must establish and maintain an expedited review process for appeals, when the Health Plan determines (for a request from a member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function.

If the Health Plan takes an action to deny, limit or delay services a member may request a State Fair Hearing after the member has exhausted the Health Plan's Appeal Process. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member by the Health Plan.

3.15 Payment To and From Health Plans

The Bidder accepts the capitation rates as contained in the Model Contract. The State makes capitation payments to the Health Plan on a monthly basis via electronic funds transfer as described in Section 3.15 of the Model Contract.

The State believes that one of the advantages of a managed care system is that it permits Health Plans to conduct selective competitive procurement processes with providers. EOHHS is committed to achieving maximum value for the investment of state dollars. The use of community-based preferred providers, selected through a competitive procurement system

should improve the quality of care while reducing costs. The Health Plans are expected to implement such competitive selective procurement practices.

The Bidder is also expected to enter into creative or performance based payment arrangements intended to foster and reward effective utilization management and quality of care. The Bidder is expected to conduct procurement practices and to establish provider reimbursement systems that enhance the quality and cost-effectiveness of care.

Bidders are required to meet the requirement of the Model Contract related to: (1) special reimbursement provisions for FQHCs and RHCs, (2) paying providers within thirty (30) days of receipt of a "clean claim", (3) implementing reforms required by Rhode Island State Legislation (i.e. R.I. General Law Chapter 40-8, Section 40-8-13.4) for paying hospitals for in-patient services, (4) applying Federal and State limitations on physician incentive plans, (5) restricting payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment, (6) third party liability, (7) reinsurance, (8) maintaining reserves and accounting for incurred but not reported (IBNR) claims, (9) reimbursement to nursing homes, (10) payment adjustments with respect to non-payment of provider preventable conditions, (11) incentive payments for the attainment of performance goals, and (12) the State conducting audits of the Health Plan.

Third Party Liability (TPL) is one of three components of EOHHS Program Integrity efforts (compliance and fraud/abuse are the other two that are subsequently discussed). Health Plans are expected to make every effort to identify and pursue TPL to the fullest extent possible to assure that other funds are used before Medicaid funds are expended, including but not limited to: (1) identifying potential other TPL when a member initially is enrolled with a Health Plan and periodically thereafter, (2) identifying other potential TPL when adjudicating member claims (e.g. auto insurers or liability insurers when acclaim is related to an accident), (3) notifying the State Fiscal Intermediary when TPL is identified, and (4) making efforts to recover funds related to other TPL coverage.

With regard to nursing home payments, the State has implemented a new reimbursement methodology that takes into account the severity of need as well as the facilities costs. The Bidder may implement the current system or may propose their own system that reflects the State's quality indicators. The Procurement Library contains information of the State's current approach for reimbursing nursing homes.

3.16 Financial Standards, Record Retention, and Compliance

Health Plan Financial Standards

The Rhode Island Department of Business Regulation regulates the financial stability of all licensed Health Plans in Rhode Island. The Bidder agrees to comply with all Rhode Island Department of Business Regulation standards in addition to specific requirements described Section 2.16 of the Model Contract.

The success of the Rhode Island Medicaid managed care program is contingent on the financial stability of participating Health Plans. As part of its oversight activities, the State has established financial viability criteria, or benchmarks, used in measuring and tracking the fiscal status of Health Plans. The areas in which financial benchmarks are established that include the following:

- Current ratio
- Plan equity per enrollee
- Administrative expenses as a percent of capitation
- Net medical costs as a percent of capitation
- IBNR and RBUC levels, including days claims outstanding

The Bidder agrees to provide the information necessary for calculating benchmark levels and to continually meet the State's financial reporting requirement to monitor the financial conditions of the Bidder once operational. The Bidder agrees to comply with corrective actions ordered by the State to address any identified deficiencies with respect to financial benchmarks.

Record Retention

As required by Section 2.17 of the Model Contract. The Bidder retains the source records for its operational data reports and financial records for a minimum of ten (10) years and must have written policies and procedures for storing this information. The Bidder also preserves and maintains all medical records for a minimum of ten (10) years from expiration of the contract. If records are related to a case in litigation, then these records are retained during litigation and for a period of seven (7) years after the disposition of litigation.

Compliance

The compliance requirements are discussed in Section 2.18 of the Model Contract. In accordance with 42 CFR 438.608, the Bidder has administrative and management arrangements, including a mandatory written Compliance Plan, which is designed to guard against fraud and abuse. An electronic copy of the Compliance Plan including all relevant operating policies, procedures, workflows, and relevant chart of organization, and the information noted in the Model Contract are submitted to EOHHS for review and approval within ninety (90) days of the execution of the contract and then on an annual basis thereafter. Compliance is one of three component of the State's Program Integrity efforts (identification and recovery of TPL and detection and control of fraud and abuse are the other two components). Specific requirements related to identify and to control fraud and abuse are discussed in Section 3.18 of this document.

The Bidder: (1) is prohibited to have affiliations with individuals debarred by Federal agencies, (2) must disclose of the ownership and controlling interest within thirty-five (35) days of contract execution, (3) must require providers to disclose ownership and controlling interest, (4) must require each to furnish the Federal and State governments full and complete information related to business transactions, within thirty-five (35) days upon request, (5) providers must disclose any individual who has more than five (5) percent interest in the provider who was convicted of a crime, (6) discloses to the State any individual who that more than five (5)

percent ownership who has been convicted of a crime. These requirements are more fully discussed in the Model Contract.

3.17 Model Contract Attachments

The Model Contract contains the following Attachments which are critical components of the ICI or key requisites to achieving the desired procurement results. These Attachments contain: (1) schedule of in-plan benefits, (2) schedule of out-of-plan benefits, (3) schedule of non-covered services, (4) nutrition standards for adults, (5) FQHC and RHC services, (6) the Health Plans locations, (7) capitation rates, (8) insurance certificates, (9) rate setting process, (10) performance goals, (11) special terms and conditions, (12) behavioral health and substance abuse services, (13) care management protocol, (14) Nursing home transition including *Rhode to Home* requirement, (15) Quality and operations reporting requirement, and (16) Medicare readiness checklist and requirements Bidders are urged to read the Model Contract and are required to meet the requirements contained in these Attachments.

3.18 Model Contract Terms and Conditions

The Bidder is required to meet the Terms and Conditions described in Article III "Contract Terms and Conditions" of the Model Contract that covers: (1) the general provisions of the contract, (2) interpretations and disputes including compliance with Federal and State requirements, (3) contract amendments, (4) payments, (5) guarantees, warranties and certifications including "hold harmless" and insurance requirements as well as requirements related to patents and copy write infringement, non-assignment of the contract, clinical laboratory improvement amendments, (6) personnel and staffing requirements, (7) performance standards and damages including requirements related to fraud and abuse, (8) inspection of the work performed and access to information, (9) confidentiality of information, (10) termination of the contract, and (11) other required terms and conditions. Bidders are urged to review the specific requirements related to the terms and conditions in the Model Contract.

The fraud and abuse requirements merit additional discussion because they are the other component of EOHHS Program Integrity efforts which include: (1) the identification and recovery of third-party liabilities, (2) compliance plan, and (3) fraud and abuse. The first two points were discussed in the previous section, the following highlights requirements related to fraud and abuse.

The Health Plan must adopt a strategic and robust approach to the prevention, detection, investigation and reporting of potential Medicaid fraud, waste and abuse to assure that Medicaid funds are appropriately expended. Specifically, the Health Plan:

- Operates a comprehensive program for providing targeted feedback to providers and vendors whose coding, documentation, or billing, although not fraudulent, appears problematic.

- Develops mechanisms for educating members and network providers about the impacts of Medicaid fraud, waste and abuse on overall program costs and on clinical outcomes

for enrollees.

- Integrates approaches to processing and investigating leads about possible fraud, waste and abuse which may be identified from multiple sources, including the Health Plan's toll-free fraud, waste, and abuse reporting hotline, as well as calls or written correspondence directed to the Health Plan's customer service, provider relations, utilization management, medical management, and care management departments.

- Employs analytic systems which make use of algorithms to identify: billing for mutually exclusive codes; deviations from time standards; excessive daily billings; excessive diagnostic procedures; outliers in service utilization; provider peer profiling outliers; potential up-coding; potential unbundling; services billed after the date of death of the enrollee or the provider.

- Executes systematic processes for conducting special investigations, provider site inspections, and focused clinical record reviews.

- Engages with the fraud, waste and abuse detection and investigations programs operated by the Contractor's subcontractors (such as pharmacy benefits manager, vision care, durable medical equipment, and behavioral health subcontractor).

- Demonstrates interfaces between the Bidder's medical management, provider credentialing, utilization management, compliance, legal, and special investigations units to analyze patterns of apparent over-utilization on the part of providers, vendors, or members.

- Uses a cohesive approach to synthesizing quantitative and qualitative data to determine whether possible Medicaid fraud, waste and abuse have been discovered.

- Makes referrals to EOHHS in a secure, timely, and thorough manner when the Bidder's initial investigation concludes that a case has reached the level of a suspected case of fraud and abuse on the part of a provider, vendor, or enrollee.

3.19 Evidenced Based Best Practices

EOHHS expects Bidders to implement evidenced-based "best practices" that have demonstrated success in advancing the goals of this procurement and the tenets of an integrated system. "Best practices" may be related to: improving a member's health care status and quality of life, enhancing health outcomes; promoting a person-centered system; maintaining effective care management practices that promote integration and coordination of care; inclusion of non-traditional providers to maximize limited medical resources, effective transition management practices that provide seamless care when members move between levels of care, or enhanced member services to foster a member's self-reliance and independence. These "best practices" may either be operating in other state programs nationally or in the Bidder's current program.

The following are "best practices" that are presented as illustrative examples of the types of "best practices" that EOHHS expects Bidder's to implement under this procurement.

Coleman Care Transitions Intervention

Care Transitions Intervention® is a program based on the work of Eric Coleman, M.D. based in the Division of Health Policy Research at the University of Colorado Denver, School of Medicine. Care Transitions Intervention® is designed to improve care transitions from hospitals to home by providing patients with tools and support that increase their knowledge and enhance self-management to ensure a safe and lasting transition. The program is based on a patient-centered system and interdisciplinary interventions that addresses continuity of care across multiple settings and practitioners. The program is composed of the following components:

- A patient-centered record consisting of essential care elements to facilitate interdisciplinary communication during the transition
- A structured checklist of critical activities designed to empower patients prior to discharge.
- A patient self-activation and management session with a Transition Coach® in the hospital
- Transition Coach® follow-up visits in the Skilled Nursing Facility (SNF) and/or in the home along with phone calls designed to sustain the previous three components and provide continued support and coordination during the transition period.

The program supports the patients for a four week period after hospital discharge.

The results of the program are promising. Hospital re-admission rates within thirty (30) after discharge were 8.9 percent as compared to 13.8 percent for those who did not participate in the program. Emergency Room visits within thirty (30) days of discharge were 11.0 percent for individuals participating in the program as compared with fourteen (14) percent for those who did not participate in the program. It is expected that the positive results of this program will be sustained over time because patients indicated a high level of confidence in obtaining essential information for management of their condition, understanding medication, and communicating with the healthcare team.

Health Care Concierge Program – UPMC

The University of Pittsburgh Medical College (UPMC) Health Plan has implemented a Health Care Concierge Program to enhance their Member services. The program assigns a Member

Service representative to each member. The goal is to establish a relationship with members through regular periodic communications to identify care needs on a timely basis and to assist Member's access to required services and care, when needed. The representative is knowledgeable about the available Health Plan services and resources (e.g. disease management, case management, and wellness programs) and links members to them.

The Health Care Concierge Model is complementary with a patient-centered medical home. The model focuses on high touch and frequent outreach and contact with member that includes:

- Welcome Calls
- Birthday Calls
- Educational Information
- Assisting members in making appointments
- Reminder Notices or Calls for check-ups or changes in Health Plan benefits or procedures
- Ninety (90) Day Check-In Calls
- Outreach for some gaps in care, such as mammograms, bone mineral density testing, diabetic care, and well visits

The Health Care Concierge Model enhances communication between the member and the Health Plan, ensures better collaboration with providers and clinical staff, builds a more knowledgeable member population that facilitates self-reliance, establishes a more integrated and coordinated approach to care delivery.

U.S. Department of Veterans Affairs - HBPC

The Department of Veterans Affairs (VA) administers the Home Based Primary Care (HBPC) program. HBPC is health care services provided to veterans in their homes for veterans who have complex, chronic and disabling medical conditions and for whom routine access to clinic-based care is not practical. An Interdisciplinary Team is established to provide care that includes a physician, social worker, rehabilitation therapist, dietician, pharmacist, and psychologist.

The VA physician supervises the health care team who provides the services. HBPC includes:

- Primary care visits at home by a physician, nurse practitioner or physician's assistant
- Care management through a nurse practitioner, physician's assistant, or nurse
- Therapy visits from a physical, occupational, or speech therapist
- Mental health services
- Nutrition counseling from a dietitian
- Help managing medicines

HBPC also provides the range of home and community-based services that veterans require so that they may remain in the home. Examples of such services include, but are not limited to: nursing home services, case management and medication management, home health services, and home care services that help members with daily living activities.

Based on a 2002 national evaluation conducted by the VA, participants in this program experienced a sixty two (62) percent reduction in bed days and an eighty eight (88) percent reduction in nursing home day than the veteran population not participating in HBPC. The costs associated with HBPC recipients decreased by twenty four (24) percent from six (6) months prior to program participation to six (6) months after program participation. Over eleven thousand (11,000) veterans participated in HBPC in 2002.

Optum Health Plan and INSPIRIS

The Optum Health Plan in collaboration with INSPIRIS implemented a CarePlus^{SM} program that focuses on improving care for the most chronically ill and costliest members. The program targets members who have a history of over utilization of high-cost services, such as Emergency Room (ER) visits and acute admissions. INSPIRIS' high-touch, comprehensive CarePlus^{SM} program addresses the needs of these complex members by sending a physician or nurse practitioner experienced in managing people with complex, chronic illness to the member's home to address their multidimensional needs. Regular provider visits are enhanced by telephonic Nurse Care Managers and Care Management Assistants who educate, support and assist with Plan of Care compliance. Members participating in the CarePlus^{SM} program benefit from care team interventions that provide person-centered care and assist members and their caregivers with:

- Self-management education
- Early identification of risks
- Alignment of treatment goals
- Suggestions to improve home safety
- Medication management and adherence observations and suggestions
- Treatment plan adherence and coordination of care with primary care providers

The ooutcomes of Optum Health Plan are significant. Based on an evaluation study of eight hundred (800) high cost, high risk, Medicaid/Medicare Health Plan members in Arizona, there was a sixty (60) percent reduction in inpatient admissions which resulted in over a $10 million cost savings to the Health Plan.

CenseoHealth

CenseoHealth recognizes the importance that data analytics can play in providing quality community based care for MME members. The program focuses on gathering pertinent data, translating data elements into intelligible action plans, and getting that information in the hands of providers and caregivers who can make effective use of that information. The data for developing the plans of care are collected through an initial assessment, wellness visits, and home visits. This data is used to develop plain language actionable plans of care that use published standards of care. The company is used by Health Plans when serving the MME population and in administering risk adjustment agreements.

ConseoHealth uses The Advanced Evaluation™ which is an in-home, face to face member

evaluation conducted by one of CenseoHealth's physician evaluators. CenseoHealth has a national network of 10,000 physicians. Health Plans receive meaningful information about their most vulnerable members and their evaluation model ensures a seamless follow-up with members and their physicians to close gaps in care.

The ConseoHealth system improves the development and follow-up of Plans of Care, improves the integration and coordination of care, and promotes the measurement of care delivery outcomes.

SeniorBridge Care Management

SeniorBridge is a national healthcare company that provides care management to individuals with complex chronic conditions. The company was founded in 2002, is NCQA accredited and operates in ten states. SeniorBridge uses an integrated model of care managers and caregivers to address the entire well-being of its clients and their families. SeniorBridge services are particularly helpful to individuals with chronic conditions such as Parkinson's disease, congestive health failure, chronic obstructive pulmonary disease, or Alzheimer's disease. A comprehensive program is provided that includes assessment, planning, service coordination, advocacy, and direct care by an interdisciplinary team led by a geriatric care manager.

The SeniorBridge approach to care is based on an integrated practice team that may include depending on member needs: Licensed Registered Nurses (RNs), Licensed Social Workers, Certified Home Health Aides (CHHA), Certified Nursing Assistants (CNAs), Licensed Practical Nurses (LPNs), and/or Specialty Companions. Licensed Registered Nurses and Licensed Social Workers make regular home visits, ensure doctor's orders are followed, reconcile and monitor medications and home safety, support family decision making, and address mood and behavioral problems. SeniorBridge clinical professionals are on-call 24 hours 7 days a week. SeniorBridge CHHAs, CNAs, LPNs and Specialty Companions perform hourly and live-in support services such as: Companionship, meal preparation, light housekeeping, shopping and errands, personal care, bathing and hygiene assistance, transferring, and transportation. SeniorBridge also provides social benefits such as helping families to evaluate and manage finances, making the home safe or select alternate housing, accessing insurance benefits, and identifying community resources. The program also applies innovative uses of telecommunication technology for members in remote locations. The program employs a web-based information system that contains an assessment tool that stratifies risk, an electronic health record, and a community resource directory.

The SeniorBridge model is based on the following guiding principles and "best practices" to manage chronic complex care in the home: (1) establish trust through communication, (2) ensure communication and coordination of care, (3) select, train and supervise paraprofessional caregivers according to the patient's changing needs, and (5) create an ethics committee to help the integrated team, family and client resolve complex issues.

3.20 Model Contract Addendums

The Model Contract contains addendums and critical requirements that the Bidder is expected

to meet. These requirements are related to: (1) fiscal assurance, (2) notice to EOHHS providers of their responsibilities under Title VI of the Civil Rights Act of 1964, (3) notice to EOHHS providers of their responsibilities under Section 504 of the Rehabilitation Act of 1973, (4) drug free work place policy, (5) drug free work place provider certificate of compliance, (6) subcontractor compliance, (7) certification regarding environmental tobacco smoke, (8) instructions for certification regarding the debarment , suspension and other responsibility matters primary covered transactions, (9) certification regarding lobbying, (10) supplemental terms and conditions for contracts funded whole or in part by the American Recovery and Reinvestment Act of 2009, and (11) business associate agreement.

The addendums are signed prior to the commencement date of the contract.

CHAPTER FOUR: PROPOSAL SUBMISSION REQUIREMENTS

This chapter describes the instructions for Bidders to follow in preparing and submitting bids. Failure to comply with these instructions in full may result in a Bidder's disqualification. The State also reserves the right to reject any and all proposals received or to cancel this LOI according to the best interests of the State. The response to this LOI requires only a technical proposal. The required format for preparing the Technical Proposal is described below.

4.1 Pre-Bid Conference

No pre-bid conference shall be conducted.

4.2 Submission of Questions

Questions concerning this solicitation may be e-mailed to the Division of Purchases at David.Francis@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. Please reference **LOI # 7461245** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

Offerors are encouraged to submit written questions to the Division of Purchases. No other contact with State parties will be permitted. Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

4.3 Procurement Library

For more detailed information regarding the Rhode Island Medicaid Program, see the following Procurement Library at the following web-site:
http://www.ohhs.ri.gov/integratedcare/newsandupdates/

The following documents are available in the Procurement Library.

Long Term Services Supports (LTSS)

- Awareness of and Need for Home and Community Based Services for Rhode Island Adults on Medicaid "Snapshot" Survey Results
- EOHHS/Medicaid Nursing Home Reimbursement Methodology Overview
- Maintaining Community Residence for People with Long Term Care Needs: A Literature Review of Factors Associated with Physical Decline, Cognitive Decline, and Nursing Home Placement
- Rhode Island Nursing Facility Payment Method Policy Design Document

- Rules and Regulations for Licensing Home Nursing Care Providers and Home Care Providers
- Change in the Characteristics of Rhode Island Medicaid Population in Nursing Homes 2008 - 2010

Personal Choice Program (Self-Direction)

- RI Medicaid Personal Choice Program Rules and Regulations
- Checklist for Managed Care Organizations Implementing Participant-Directed Service Options
- Developing and Implementing Self-Direction Programs and Policies: A Handbook
- Participant Direction in Managed Care: Center for Health Care Strategies August Call 2012
- Participant-Directed Roles and Responsibilities
- Personal Choice Program: Participant/Representative User Manual
- Personal Choice Program: Provider Manual

Assisted Living

- Medicaid Assisted Living in Rhode Island: Evaluation of Payment Methods

Money Follows the Person (MFP) & Nursing Home Transition Programs (NHTP)

- Money Follows the Person Operational Protocol for the Rhode Island: The Rhode to Home Demonstration Project
- Crosswalk Between State Service Codes and Type of MFP Services
- Overview and File Layout for Quarterly MFP Services File
- Overview and File Layout for Quarterly MFP Finders File
- Overview and File Layout for Quarterly MFP Participation Data File
- MFP Quality of Life Survey Tracking Form
- MFP Grantee Help File
- Staff Training Manual for the Nursing Home Transitions Program and Money Follows the Person/Rhode to Home

Shared Living

- Rite @ Home... A Choice for Care @ Home: Program Standards

Safe Transitions

- Improving Care Transitions for Rhode Island Patients

U.S. Department of Veterans Affairs

- Exploring New Roles for Home Care Workers

- Financial Savings of Home Based Primary Care for Frail Veterans with Chronic Disease
- Providence VA Medical Center: Home Based Primary Care (HBPC) Presentation
- Veteran's Affairs Home Based Primary Care Study
- VHA Handbook: Home-Based Primary Care Program

Rhode Island Chronic Care Sustainability Initiative

- Key Dates for CSI Patient Centered Medical Homes
- Rhode Island Chronic Care Sustainability Initiative Agreement Contract Template

Balancing Incentive Program (BIP)

- Balancing Incentive Program: Implementation Manual

Housing

- Rhode Island 2012 Housing Fact Book
- List of Rhode Island Homeless Shelters

Chronic Disease Education

- HEALTH's Chronic Conditions Integrated Work Force System

Quality Management

- Healthcare Disparities and Cultural Competency Measures

Data

- Data Book – Rhode Island Long Term Care Graphs
- Family Shelter Data
- Harrington House Data
- 2012 Annual Disability Statistics Compendium

Additional Information

- 2012 Rate Review Process Hospital Contracting Condition
- Contract Attachments
- Contract Timeline Overview
- The Affordability Standards: A Summary
- System Affordability Priorities and Standards for Health Insurers in Rhode Island

4.4 Proposal Submission

Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after

this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

Proposals must include the following:

1. A letter of transmittal signed by the owner, officer or authorized agent of the firm or organization, acknowledging and accepting the terms and conditions of this LOI, and tendering an offer to the State.

2. A Technical Proposal describing the background, qualifications and experience with and for similar programs, as well as the work plan or approach proposed for this LOI. The Bidder shall submit only a Technical Proposal, a cost proposal is not necessary, the Bidders are required to accept the capitation payments reflected in the model contract as appended in this LOI.

The technical proposal must contain the following sections:

1. Transmittal Letter (see above)
2. Assurances/Attestations
3. Bidder Experience and Understanding
4. Technical Response

    A) Plan for Enrollment
    B) Plan for Providing Covered Services and Meeting Accessibility Standards
    C) Plan for Maintaining a Robust Provider Network including the Development of Patient-Centered Medical Homes
    D) Plan for Operating a Person-Centered System
    E) Plan for Conducting Risk Profiling
    F) Plan for Providing Care Management
    G) Plan for Serving Nursing Home Transition Members, including RTH
    H) Plan for Providing Member and Provider Services
    I) Plan for Conducting Medical Management and Quality Assurance Efforts
    J) Plan for Reimbursing Providers
    K) Plan for Implementing Evidenced-Based Best Practices
    L) Plan for Including a Preventive Oral Health Benefit in Contract Year Two
    M) Plan for Complying with Phase II Requirements

5. Additional Technical Response from New Bidders (if applicable)

Proposals (an original plus seven (7) copies) and two (2) electronic (Compact Disc or thumb drive) copies should be mailed or hand delivered in a sealed envelope marked "**LOI # 7461245 Medicaid Managed Care Services**" to:

RI Dept. of Administration
Division of Purchases, 2nd floor
One Capitol Hill
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed, or emailed, to the Division of Purchases will not be considered. The official time clock is in the reception area of the Division of Purchases.

4.5 Response Limits

The State does not want Bidders to develop excessively elaborate responses to this LOI. The Technical Proposal shall be limited to **125 single-spaced pages (using a font not smaller than 12 points)**; excluding the following components: the transmittal letter, the additional technical responses from new Bidders and pertinent attachments the Bidder would like to share with the State or any specific attachments asked for by the State.

4.6 Technical Proposal Specifications

The following sections provide information on the specifications for the Technical Proposal, including suggested page allocations.

4.6.1 Transmittal Letter

The transmittal letter shall include statements regarding the following:

a) A statement that the Bidder has read, understands and accepts the conditions and limitations of this LOI
b) A statement that the Technical Proposal is effective for one hundred and twenty (120) days from the date of submission
c) Identification of any proposed sub-contractor arrangements in the proposal
d) Identification of the person who will serve as primary contact for the Bidder, including the individual's address, telephone number, fax number and email address
e) Any other information that the Bidder may want to convey to the State

4.6.2 Assurances/Attestations

All Bidders at minimum shall include the following statements and assurances in their proposals.

- **A statement** that the Bidder is a corporation or other legal entity and is properly licensed to operate as a health maintenance organization or as a Health Plan within Rhode Island; and is NCQA accredited in Rhode Island or NCQA accredited in another State and will be accredited within twelve (12) months of the effective start date of a contract pursuant to this LOI.

- **A statement** that the Bidder has submitted a Notice of Intent to Apply (NOIA) for participation in the capitated financial alignment model for MMEs; has submitted an

application via the Health Plan Management System (HPMS) to participate in the financial alignment demonstration; will submit the additional required materials via HPMS (MTMP, Part D formulary, plan benefit package, Additional Demonstration Drug and Part D supplemental formulary files) by their respective deadlines; and understands and will meet all Medicare requirements for the financial alignment model, including Part D.

- **A statement** of whether the Bidder or any of the Bidder's employees, agents, independent contractors or subcontractors have been convicted of, pled guilty to or pled *nolo contendere* to any felony and/or any Medicaid or health care related offense or have been debarred or suspended by any Federal or State governmental body, and if so, an explanation providing relevant details. Bidder shall include the bidder's parent organization, affiliates and subsidiaries.

- **A statement** that the Bidder has read, understands, and accepts the mandatory requirements, responsibilities, and terms and conditions associated with this procurement, as reflected in the Model Contract.

- **A statement** that the Bidder accepts the State's Capitation Rates that will be paid to the successful bidders.

- **A statement** of Affirmative Action that the Bidder does not discriminate in its employment practices with regard to race, color, religion, age (except as provided by law), sex, marital status, sexual orientation, political affiliation, national origin, or handicap and complies with the Americans with Disabilities Act.

Bidders shall submit copies of their State Licenses; NCQA Accreditation Certificates; and CMS approval for being a MAP or SNP or proof that the Bidder has applied to CMS for such approval with their proposal.

4.6.3 Experience and Understanding

The Bidder should include the following information in this section:

- Description of the Bidder, and its subcontractors, regarding the type of organization and ownership; historical perspective of organization; special Federal and State designation businesses (e.g. small businesses, minority/women owned business and disability business enterprises); size of company, national recognitions; and other information that the bidder would deem appropriate.

- Recent NCQA ranking (e.g. Excellent, Commendable, Accredited, Provisional, or Denied) in Rhode Island or in other States if not operating in Rhode Island as well as NCQA HEDIS® 2009 Score results in Rhode Island or in other States if not operating in Rhode Island.

- Experience in providing Medicaid services as a Health Plan in Rhode Island under a risk-based contract and the populations served.

- Experience in serving as a commercial Health Plan in Rhode Island under a risk-based contract.

- Experience in serving Medicare Beneficiaries.

- Experience in serving Medicaid Beneficiaries

- Experience in serving the MME population.
- An understanding of the RI environment; the conditions surrounding this procurement and; knowledge of and experience with the Medicaid population in other states.

- The capability and capacity of the Bidder to provide the Medicaid services to the eligible populations under a risk sharing arrangement.

- The financial viability of the Bidder (as well as adverse factors that may affect the Bidder's financial viability including but not limited to bankruptcy proceedings, major lawsuits, fines).

- The ability to be ready to serve members by the stated contract commencement date.
- The composition of the Consumer Advisory Committee.
- The status of the Bidder's financial alignment demonstration application and the status of any other materials required to be submitted via HPMS for participation in the capitated financial alignment model, including materials submitted and forthcoming.

The Bidder may provide other information it believes is essential to provide value-based quality services to the Medicaid populations.

4.6.4 Technical Response

The following describes the Technical Responses required from the Bidder.

A) **Plan for Enrollment**

The Bidder should discuss its plan for enrolling the Rhody Health Options populations. As part of its response, the Bidder should highlight its capability and its policies, procedures and practices to: (1) accept the State supplied monthly list of Health Plan enrollees, (2) enroll members within seven (7) calendar days after receiving notification from the State, (3) mail notification of Health Plan enrollment to members including effective date and how to access care within ten calendar days after receiving notification from the State, (4) provide orientation to new Member about their benefits, the role of the PCP, what to do in an emergency or urgent medical situation, how to utilize services in other circumstances, how to register a complaint or file a grievance and advance directives in accordance with Federal and State legal requirements,

(5) make at least four (4) attempts, on different days, to make a welcome call to all new members within thirty (30) days of enrollment to provide the same information, (6) provide members with a permanent identification card within ten (10) days after receiving notification from the State, (7) make at least four attempts, not counting two on the same day**,** to contact the member within ten days of notification of enrollment to provide information on options for selecting a PCP. (8) mails a Member Handbook to all members within ten days of being notified of their enrollment, (9) publishes a revised Member Handbook within six months of the effective contract date, and to update the Member Handbook thereafter when there are new topics, (10) develop marketing materials with EOHHS approval, (11) discuss the contents of materials and documents noted above, (12) supplying information to members that are presented in a culturally and disability competent manner, and (13) other topics deemed appropriate by the Bidder.

B) **Plan for Providing Covered Services and Meeting Accessibility Standards**

The Bidder should discuss its plan for providing the covered services and meeting accessibility standards contained in the Model Contract. Specifically, the Bidder should describe: (1) the full range of primary care, acute care, specialty care, behavioral health care, and LTSS (institutional care and home and community-based services and supports, including a detailed description of the tools or methodology used to determine LTSS service authorization levels, (2) the service accessibility standards that governs the provision of services including 24 hour 7 day per week coverage, in particular 24/7 coverage for LTSS needs, (3) additional standards that the Bidder employs above Model Contract requirements, (4) how the Bidder coordinates services for individuals with Developmental Disabilities and individuals with SPMI that will continue to be funded and managed by the BHDDH providers, (5) special programs and services that is provided by the Bidder to Rhody Health Options members to meet their special needs (e.g. Disease Management Program, Self-Help Medical Management, Pain Management programs, or other services provided by the Health Plan), (6) plan for honoring all existing service authorizations for the designated transition period, (7) intervention strategies to identify and rectify unnecessary use of the ER, preventable hospital admissions or avoidable institutionalizations, (8) demonstrate capability to provide services to individuals with SPMI and individuals with developmental disabilities in Phase II, and (9) other topics deemed appropriate by the Bidder.

C) **Plan for Maintaining a Robust Provider Network Including the Development of Patient-Centered Medical Homes**

The Bidder should discuss its plan to develop and maintain a robust and comprehensive network of providers to meet the diverse and complex needs of the Rhody Health Options members. Specifically, the Plan should describe: (1) how the Bidder will provide members with the full range of covered services primary care, acute care, specialty care, behavioral health care and long-term care services and supports for the anticipated members in the service area, (2) maintain providers in sufficient number, mix and geographic area, (3) make available all services in a timely manner. (4) the specific LTSS network (i.e. institutional and HCBS providers) including a geographic access analysis of the LTSS network to determine the accessibility of services, (5) the specific role of PCPs, (6) the employment of NCQA recognized

PCMH sites in its network to serve as PCPs, (7) how the Bidder will monitor providers to ensure that they meet Federal and State requirements, (8) what steps the Bidder takes to assure the requisites of a person-centered system of care are met by providers, (9) effective measures that is put in place by the Bidder to improve provider capability to improve the cost-effectiveness of care, (10) the development of a home-based primary care provider network , (11) efforts to meet State affordability standards, (12) approach to maintain the existing network of providers for s transitioning to managed care, as well as maintaining the EOHHS contracts with essential community providers for one (1) year, and (13) other topics deemed appropriate by the Bidder.

The Bidder should demonstrate familiarity with the PCMH model. Responses should specify: (1) what payment methodologies Bidder proposes to support and encourage medical home development and sustainability, (2) how the Bidder will encourage non-PCMH practices to become recognized medical homes, (3) the Bidder's expectations and proposed milestones for PCMH implementation for the MME population served, e.g. how many new medical homes will be supported per year, (4) what, if any, special expectations the Bidder will have for medical homes serving the dual MME population, (5) how the Bidder will contract with hospitals and specialists to ensure collaboration with medical homes, (6) how the Bidder will implement and support care management services that are integrated with medical homes, (7) what methods the Bidder will use to attribute the dual MME population to a medical home, and (8) how the Bidder will measure medical home implementation. If the Bidder proposes using a provider contracting standard different from that developed for CSI RI, they should explain how and why the Bidder's contracts with PCMH's will differ. CSI contracting standards are available in the procurement library at http://www.ohhs.ri.gov.

In the description of the network of home care agencies, the Bidder should distinguish which agencies are Medicare certified, and which agencies are overseen by Medicare-certified agencies.

D) Plan for Operating a Person-Centered System

The Bidder should discuss its plan to develop and maintain a person-centered system of care. As part of its discussion, the Bidder should describe: (1) their person-centered system, (2) how it may vary among Rhody Health Partner and Rhody Health Options sub-populations (e.g. the disabled vs. elders; those receiving LTSS and those not receiving LTSS; and by care setting i.e. those in institutional vs. those in home or community care) if at all, (3) how the requisites of a person-centered system is incorporated throughout the development of the Plan of Care and delivery process, (4) how a self-directed services model will be incorporated into the delivery process, (5) plan for including EOHHS' essential community providers as well as *RTH* supports and contracting with specialty providers, (6) the role of the Advisory Committee, and (7) other topics deemed appropriate by the Bidder.

E) Plan for Conducting Risk Profiling

The Bidder should discuss its plan to conduct risk profiling to identify those in need of care

management and to serve as an early warning system to identify those "at risk" of requiring care management, and to identify those who may benefit from care management. Specifically the Bidder should describe: (1) its overall approach to conducting risk profiling, (2) its analysis to initially identify members in need of care management through an analysis of claims data and the outcome of the initial screen, (3) the use of predictive models to identify the population requiring, or at risk of requiring, care management, (4) how it will determine who is "at risk" or will benefit from care management, (5) the models, classifications and definitions that will be used to stratify populations in terms of their need for care management, (6) the levels of care management or specific care management services that will be given to members will different care management needs, (7) the identification of risk behaviors or risk conditions of members throughout the intervention process signifies the need for care management, (8) the anticipated benefits of risk profiling, (9) the time schedule for operating a comprehensive risk-profiling and early identification system, and (10) other topics deemed appropriate by the Bidder.

F) Plan for Providing Care Management

The Bidder should discuss its plan for providing care management. As part of its discussion the Bidder will describe its policies, approaches, practices, decision-making criteria, instruments and protocols, and expected outcomes for each component of the care management process, including but not limited to: (1) telephonic screen assessment, (2) comprehensive functional needs assessment, (3) designated care manager, (4) develop a Plan of Care, including a detailed description of how service levels are authorized and the specific tool used to determine service authorization levels, (5) multi-disciplinary care team, (6) proposal for ratios of lead care managers to members, (7) conflict free case management, (8) implementation, coordination and monitoring of the Plan of Care, (9) transition planning when member transitions between levels of care, (10) analysis of care management with regards to the effectiveness, appropriateness, and outcomes of care management including reporting care management information to EOHHS, (11) the conditions and frequency of face-to-face contact with members, (12) plan for providing conflict free care management, (13) plan for reporting care management activities and results to EOHHS based on prescribed guidelines, and (14) other topics deemed appropriate by the Bidder.

G) Plan for Serving Nursing Home Transition Members including RTH

The Bidder should discuss its plan for serving members interested in transitioning from a nursing home to a community-based residence while maintaining compliance with Nursing Home Transition and RTH requirements. The Bidder should describe its plan for meeting EOHHS requirements related to: (1) the overall model or system that will be used for transitioning members, (2) the processing of MDS Section Q referrals, (3) the process for providing comprehensive LTC Options Counseling, (4) the process for identifying potential transition candidates in nursing facilities, outlining those of which meet RTH qualifications, and notifying EOHHS, (5) the process for supporting eligibility determination for MFP, (6) the process for linking members to affordable housing, (7) the transition process to a community-based residence including the conducting of a Comprehensive Clinical Assessment, the development of an individualized person-centered Plan of Care, Transition Coordination and Care Management, Ongoing Care Management and conduct of Quality of Life surveys, (8)

specialized care management and the employment of transition coordinators, peer navigators/peer mentors or ombudsman, (9) the identification and reporting of critical incidences to EOHHS and providing support to members, (10) the process for developing Emergency Back-Up Plans and for providing support to members, when needed, (11) reporting required information to EOHHS, (12) the protocols, assessment tools and documentation tools that are used throughout the *RTH* process, and (13) other factors or processes the Bidder believes is vital in meeting *RTH* requirements.

H) **Plan for Providing Member and Provider Services**

The Bidder should discuss its plan for providing member and provider services as described in Sections 2.10 and 2.11 of the Model Contract, respectively. The Bidder describes its efforts: (1) to provide multi-lingual, culturally competent and disability centric member services, and (2) to enhance provider services that promote the integration and coordination of care.

I) **Plan for Conducting Medical Management and Quality Assurance Efforts**

The Bidder should discuss its plan for conducting medical management activities and to ensuring quality of care as described in Section 2.12 of the Model Contract. The Bidder describes its plans with regard to: (1) the Medical Director's background and experience as well as his/her role and responsibilities, (2) utilization review protocols and criteria used that affect the approval or denial of care, (3) strategies, programs and practices to assure quality of care, (4) the employment of practice guidelines, and (5) provider credentialing activities.

J) **Plan for Reimbursing Providers**

The Bidder should discuss its plan for reimbursing providers. Specifically, the Bidder will describe: (1) the employment of competitive selective procurement practices to improve the quality and reduce the cost of care and specify which services or care it will be used for, (2) the use of creative or performance based reimbursement arrangements intended to foster and reward effective utilization management and quality assurance, (3) payments to providers including but not limited to pharmacies, behavioral health specialists, HCBS providers, care management and support service agencies, (4) how the Bidder intends to reimburse hospitals and meet the requirements of the Model Contract, (5) how the Bidder will reimburse nursing homes and whether it will use the State methodology or the Health Plan's own approach, (6) the Bidders approach to reimbursing HCBS agencies and how that approach differs from the State's current methodology, (7) anticipated results or savings that will be produced as a result of the Health Plan's TPL efforts, and (8) how the Bidder will meet the other requirements that is described in Section 2.15 of the Model Contract.

K) Plan for Implementing Evidenced-Based Best Practices

The Bidder should describe its plan for implementing evidenced-based best practices that are nationally recognized or from the Bidder's own program. Best-practices relate to, but not limited to: (1) enrollment practices, (2) services and accessibility, (3) provider network, (4)

person-centered system, (5) risk profiling, (6) patient-centered medical homes (7) care management practices, (8) member and provider services, (9) medical management and quality assurance, (10) operational reporting and management information systems, (11) procurement practices and provider reimbursement, (11) program integrity, (12) advisory committee participation, and (13) other areas deemed appropriate by the Bidder.

L) Plan for Implementing Preventive Oral Health Benefits

A large area of unmet need, as well as a primary driver of emergency utilization is the lack of access to adequate oral health care. The Bidder should describe a proposal to include a preventive oral health benefit into the package of in-plan services for Contract Year Two. This Plan should include the scope of benefits, the network recruitment and reimbursement strategy, and the education plan for members on the importance of preventive oral health.

M) Plan for Complying with Phase II Requirements

The Bidder shall describe in detail its ability to comply with the requirements for Phase II of the Integrated Care Initiative described in this LOI, specifically the requirements imposed by CMS as well as the ability to serve all Medicaid enrollees, and serve adults with Developmental Disabilities and Severe and Persistent Mental Illness. Bidders should acknowledge that RI will also use the bidder's past performance/LPI status as criteria in the selection process.

4.6.5 New Bidder Requirements (Maximum of Forty pages excluding appendices with pertinent information)

Bidders who have not had prior experience and a contract to serve the Medicaid population in Rhode Island also must submit the following additional information:

- **Organizational description**: The Bidder should describe: the structure of the organization, provide an organizational chart, its organizational and financial relationship to any parent organization that is associated with the Health Plan, and its financial viability (including adverse factors that may affect the Bidder's financial viability including but not limited to bankruptcy proceedings, major lawsuits, fines).

- **Provider network**: The Bidder should include as an attachment to its proposal a complete listing of its' provider network including names, addresses, telephone numbers, provider specialties and foreign language(s) spoken (if any). The Plan will include a GeoAccess analysis that demonstrates that the network is sufficiently robust and assures timely access to services for Medicaid members and is currently accepting new members. Its network must include a plan for meeting the multi-lingual/multi-cultural/geographic and other special needs of the Rhody Health Options populations. The provider network complies with the requirements outlined in Section 2.08 of the model contract.

- **Operational Data Reporting:** The Bidder should describe its plan to meet the operational reporting requirements as described in Section 2.13 of the Model Contract

including submission of the encounter data, and operational reports as described in the Model Contract.

- **Grievance and Appeals**: The Bidder should describe its plan to meet Federal and State grievance and appeals requirements described in Section 2.14 of the Model Contract.

- **Reinsurance:** The Bidder should describe its Plan for reinsurance to cover the Medicaid population that describes the type, coverage, limits and insurer for the re-insurance.

- **Program Integrity:** The Bidder should describe its plan to implement the program integrity requirements of the Model Contract. The Plan will include the policies and practices that cover the Bidder's proposed plan to meet the Model Contact requirements related to: (1) Medicaid fraud, waste and abuse, (2) corporate compliance, and (3) TPL identification and recovery.

- **Financial Standards, Record Retention and Compliance Requirements:** The Bidder should describe its plan for meeting the Model Contract requirements related to: (1) financial standards as described in Section 2.16, (2) record retention as described in Section 2.17, and (3) compliance as described in Section 2.18.

- **Meeting Model Contract Amendments and Terms and Conditions:** The Bidder should describe its plan for meeting contracts amendments and the terms and conditions as described in Article III of the Model Contract

4.6.6 Further Clarification of Proposals and Oral Presentations

The State reserves the right to ask parties submitting proposals to provide additional information or clarification about their proposal in writing, verbally or both. The State may interview representatives of parties submitting proposals or ask them to conduct oral presentations about their proposals. The State also may request an on-site tour and inspection of facilities and operations of parties submitting proposals.

4.6.7 Bid Amendments

It may be necessary for the State to issue amendments to these bid specifications prior to awarding contracts. If this occurs, Bidders will be provided with instructions on how to modify their proposals as necessary to accommodate the bid specifications amendments and will be given reasonable time in which to formulate a response.

4.7 Evaluation Committee

The State will commission a Technical Review Committee, which will evaluate and score all proposals. Only State Personnel will serve as voting members of the Technical Review Committee. However, the State may designate other individuals to serve as staff to the Technical Review Committee and to provide assistance in the evaluation activities.

4.8 Evaluation Process

The State will conduct a comprehensive and impartial evaluation of all bids. The Technical Proposals will be evaluated against a set of minimum standards, to identify any proposals that are incomplete or unresponsive. The State reserves the right to contract with two or more Health Plans. The State, through its Technical Review Committee, will be the sole judge in reviewing proposals and awarding contracts.

The State will evaluate and score all proposals using the following criteria:

- **Provision of Required Information and Assurances/Attestations (Pass/Fail):** Bids will be evaluated to determine whether Bidder's provided the necessary information in the Transmittal Letter and that all the Assurances/Attestations have been completed.

- **Experience and Understanding from All Bidders (20%):** The Bidder's experience and understanding should address the following topics:

  Description of the Bidder, and its subcontractors, including the type of organization and ownership; historical perspective of organization; special Federal and State designation businesses (e.g. small businesses, minority/women owned business and disability business enterprises); size of company; national recognitions; and other information that the Bidder deems appropriate.

  Recent NCQA ranking (e.g. Excellent, Commendable, Accredited, Provisional, or Denied) in Rhode Island or in other States if not operating in Rhode Island and NCQA HEDIS 2009 Score results in Rhode Island or in other States, if not operating in Rhode Island.

  Experience providing Medicaid services as a Health Plan in Rhode Island under a risk-based contract and the populations served.

  Experience serving as a commercial Health Plan in Rhode Island under a risk based contract.

  Experience serving Medicare beneficiaries and serving the MME population.

  An understanding of the RI environment; the conditions surrounding this procurement; and knowledge of and experience with serving the Medicaid populations.

  The capability of the Bidder to provide the Medicaid services to the eligible populations under a risk sharing arrangement.

  Other information the Bidder believes is essential to provide value-base quality services to the Medicaid and MME populations.

- **Technical Responses (80%):** The Bidders shall provide responses for each of the

proposal sections listed below. Responses for each section will be evaluated based on the specific information requirements noted for each section discussed in Section 4.7.4 of this LOI.

- **New Bidder Evaluations (Pass/Fail):** New Bidders will receive a "Pass" or "Fail" Grade. A "Pass" is considered as a "conditional pass" pending the results of a readiness review and the demonstrated ability of the Health Plan to meet requirements and responses to the discussion areas in Section 4.7.5 of this LOI.

4.9 Contract Award

The Technical Review Committee presents its recommendations to the Department of Administration, Office of Purchasing, who shall make the final selection for this procurement.

The State reserves the right to disqualify or not consider any proposal that is determined not to achieve the State's goals or to be in the best interest of the State. Proposals found to be technically or substantively non-responsive at any point in the evaluation process will be rejected and not receive further consideration.

The State also reserves the right to send clarifying questions and to receive clarifying responses from parties submitting LOIs, request interviews and presentations, request additional financial information, contact references, and/or use other appropriate means to evaluate a proposal and the submitting Bidder's qualifications. The State also reserves the right to specify special terms and conditions for individual Bidders as part of making awards. The award will not be considered official until the bidder complies with these terms and conditions in full.

4.10 Readiness Review

The State will conduct a "readiness review" of any Bidder to assure that they are able to implement and administer the proposed terms as required in the model contract and as described in this document. Implementation of the terms of the contract is contingent upon readiness.

4.12 Debriefing

Unsuccessful Bidders may, within thirty (30) days of the receipt of intended contract award, request a meeting for debriefing and discussion of their bids by contacting the Issuing Officer in writing. Debriefing will not include any comparisons of unsuccessful bids with other bids. Debriefings will not be held until after the contract(s) are signed and approved by all appropriate State and Federal agencies.